



**Spanish version of the Inferential Confusion Questionnaire  
expanded version: further support for the role of inferential  
confusion in obsessive-compulsive symptoms**

Journal:	<i>Clinical Psychology &amp; Psychotherapy</i>
Manuscript ID	CPP-2109.R1
Wiley - Manuscript type:	Research Article
Date Submitted by the Author:	n/a
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Keywords:	inferential confusion questionnaire, ICQ-EV, dysfunctional beliefs, Spanish version, OCD, obsessive-compulsive disorder

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Support for the Role of Inferential Confusion in Obsessive-Compulsive Symptoms

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### **Abstract**

The purposes of this research were: (1) to analyse the psychometric properties of the Inferential Confusion Questionnaire-Expanded Version (ICQ-EV) in a Spanish population; (2) to explore the role of inferential confusion in obsessive-compulsive disorder (OCD); and (3) to compare the inferential confusion construct in non-clinical and clinical samples. A sample of 342 non-clinical participants and 66 patients with OCD completed the ICQ-EV Spanish adaptation as well as a set of questionnaires. Results confirmed a good fit of the ICQ-EV Spanish version to the original unifactorial structure and excellent internal consistency and test-retest reliability. Moreover, results confirmed that the ICQ-EV predicts Obsessing, Checking, Washing, and Hoarding symptoms, independently of the contribution of dysfunctional beliefs. In addition, OCD patients scored significantly higher on the ICQ-EV than non-clinical participants. The Spanish version of the ICQ-EV is a reliable instrument to assess inferential confusion, and further support is provided for the relevance of the inferential confusion construct in OCD.

### **Key Practitioner Message**

The Spanish version of the ICQ-EV is a reliable measure.  
The Spanish version of the ICQ-EV can be used to assess inferential confusion in Spanish clinical and non-clinical participants.  
Inferential confusion predicts Obsessing, Checking, Washing, and Hoarding symptoms.  
OCD patients show higher inferential confusion than non-clinical participants do.

### **Keywords**

Inferential confusion questionnaire, ICQ-EV, Spanish version, dysfunctional beliefs, OCD, obsessive-compulsive disorder

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### Introduction

Most cognitive models of obsessive-compulsive disorder (OCD) have focused on belief domains and appraisals of intrusive thoughts to explain the development and maintenance of the disorder. These models propose that the erroneous appraisal of an intrusive thought based on OCD belief domains facilitates the transformation of a normal intrusion into an obsession (Clark, 2004; Rachman, 1997; Salkovskis, 1985). However, based on this hypothesis, not everyone shows significant improvements from cognitive therapy, and current cognitive modalities do not appear to enhance the outcome of behavioural interventions (Kozak & Foa, 1994; Veale, 2002). In addition, a percentage of people suffering from OCD do not show elevated levels of dysfunctional beliefs and appraisals (Taylor et al., 2006). Given these limitations, the inference-based approach (Aardema & O'Connor 2003, 2007; O'Connor & Robillard, 1995, 1999) suggests that factors other than appraisal alone may be involved in the development and maintenance of OCD.

According to the inference-based approach, obsessions have their origin in erroneous inductive reasoning, which has been called "inferential confusion". Inferential confusion refers to a distrust of one's senses or self and overreliance on remote possibilities during reasoning. Inferential confusion would produce obsessional doubt (Aardema et al., 2010). Obsessions take the form of an inference involving doubt about a current state of affairs, which means that obsessions are based on a possible state of affairs. The obsessional doubt (or primary inference) would appear due to the inferential confusion process, based on a narrative leading to obsessional intrusions and doubts. Subsequent appraisals may, in turn,

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2  
3 give rise to efforts to control the doubts, leading to compulsions and other ineffective thought  
4  
5 control strategies (Clark & O'Connor, 2005).  
6

7  
8 An example of the inferential confusion process embedded in an obsessional narrative  
9  
10 would be the following: "I saw this little 5-year-old boy in the shop and I thought that he  
11  
12 would be very handsome when he became a man... What kind of person thinks that of a child?  
13  
14 Normally I like men younger than me; all my boyfriends have been at least 4 years younger. I  
15  
16 remember that actor who I liked so much... He was much younger than me, 10 years less...  
17  
18 Perhaps there is something wrong with me...". The obsessional doubt or primary inference  
19  
20 resulting from such a narrative could be "Maybe I am a paedophile", potentially followed by  
21  
22 primary appraisals such as: "If I am paedophile, then I might do terrible things".  
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26 The inference-based approach is thought to be relevant in all types of OCD, although it  
27  
28 was first developed for individuals with OCD who had poor insight or overvalued ideas  
29  
30 (O'Connor & Robillard, 1995). Since its original conceptualization, a number of studies have  
31  
32 supported the role played by inferential confusion in different OCD subtypes. Emmelkamp  
33  
34 and Aardema (1999) reported that inferential confusion was a unique predictor of obsessive-  
35  
36 compulsive symptoms when controlling for depression and other cognitive domains.  
37  
38 Aardema, O'Connor, Emmelkamp, Marchand, and Todorov (2005) observed that the level of  
39  
40 inferential confusion was significantly higher in OCD and delusional participants compared to  
41  
42 control groups. OCD patients also show higher levels of inferential confusion than patients  
43  
44 with anxiety disorders (Aardema et al., 2010; Pozza, Torniai & Dèttore, 2018). The inferential  
45  
46 confusion construct has also been reported to significantly account for part of the association  
47  
48 between obsessive-compulsive symptoms and dysfunctional beliefs about thoughts (Aardema,  
49  
50 O'Connor, & Emmelkamp, 2006). Moreover, a study using an experimental reasoning task  
51  
52 (Aardema, Pélissier, O'Connor, & Lavoie, 2009) showed that subjects with OCD were more  
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54 influenced by possibility-based information than non-clinical controls, but only in their OCD  
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3 area, suggesting that participants with OCD tend to engage in negative possibilities or doubts  
4  
5 while dismissing reality that runs counter to the obsessional doubt.  
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7  
8 According to the inference-based approach, OCD patients generally do not experience  
9  
10 obsessional doubts in every area of life. Instead, concerns appear to be thematic, and  
11  
12 reasoning is based on remote possibilities rather than on the senses and common sense.  
13  
14 Similarly, OCD is a heterogeneous disorder, and not everyone experiences doubt obsessions  
15  
16 across all the symptom dimensions of OCD. Some authors have suggested vulnerable self-  
17  
18 themes that may account for symptom specificity, where the person experiences obsessions as  
19  
20 a well as inferential confusion in selected areas of life (Aardema & Wong, 2019; García-  
21  
22 Soriano & Belloch, 2012). Nonetheless, inferential confusion is considered relevant in all the  
23  
24 OCD symptom subtypes, as well as in OCD symptomatology in general, given that all forms  
25  
26 of OCD are conceptualized as originating in obsessional doubt, even though they may appear  
27  
28 in different domains. Studies suggest that inferential confusion is related to OCD  
29  
30 symptomatology as a whole, in addition to uniquely predicting specific obsessive compulsive  
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32 symptoms, but results are not consistent across studies for each symptom domain. Wu,  
33  
34 Aardema, and O'Connor (2009) reported that inferential confusion and dysfunctional beliefs  
35  
36 about thoughts accounted for different OCD symptoms. Inferential confusion predicted  
37  
38 checking symptoms; responsibility/threat estimation beliefs predicted washing; and both  
39  
40 inferential confusion and perfectionism/certainty predicted rituals. In a recent study conducted  
41  
42 in a large OCD sample, inferential confusion was especially relevant in predicting  
43  
44 indecisiveness and rumination symptoms, whereas importance/control of thoughts was  
45  
46 especially relevant in obsessions, perfectionism and certainty of precision, and just-right  
47  
48 symptoms (Aardema, Wu, Moulding, Audet & Baraby, 2018). Moreover, research shows that  
49  
50 the inferential confusion construct changes after successful OCD treatment (Aardema,  
51  
52 Emmelkamp, & O'Connor, 2005; Aardema, O'Connor, Delorme & Audet, 2016; Aardema et  
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2  
3 al., 2010; Del Borrello & O'Connor, 2014), and there is also some evidence that this  
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5 treatment is effective with body dysmorphic disorder (Taillon, O'Connor, Dupuis, & Lavoie,  
6  
7 2013), hoarding (St-Pierre-Delorme & O'Connor, 2016), and eating disorders (Purcell &  
8  
9 Connor, 2015).

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11  
12 Most studies investigating the inferential confusion construct have been conducted  
13  
14 using the Inferential Confusion Questionnaire (ICQ; Aardema et al., 2005) or its expanded  
15  
16 version (ICQ-EV; Aardema et al., 2010), instruments developed to measure the level of  
17  
18 inferential confusion, as formulated by O'Connor and Robillard (1995). Examples of items  
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20 are "I sometimes invent stories about certain problems that might be there without paying  
21  
22 attention to what I actually see" or "Even if I don't have any actual proof of a certain problem,  
23  
24 my imagination can convince me otherwise". There are two versions of the ICQ, the original  
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26 15-item version (Aardema et al., 2005) and the ICQ-EV 30-item version (Aardema et al.,  
27  
28 2010). The ICQ-EV improved the psychometric properties of the previous version.  
29  
30 Specifically, the ICQ-EV revealed a strong one-factor structure and demonstrated high and  
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32 excellent internal consistency (Cronbach's  $\alpha = .96$  in non-clinical groups,  $\alpha = .97$  in clinical  
33  
34 OCD group) and test-retest reliability (.90 with an average interval of 12 weeks, clinical OCD  
35  
36 group). Supporting its convergent validity, the ICQ-EV showed moderate to strong  
37  
38 correlations with obsessive-compulsive symptoms, independently of the thematic content, and  
39  
40 these associations remained significant when controlling for negative mood states (Aardema  
41  
42 et al., 2010). The ICQ-EV divergent validity was better than what was shown by the ICQ. In  
43  
44 this regard, although there were moderate correlations (ranging between .28 and .57) between  
45  
46 the ICQ-EV and another cognitive measure evaluating dysfunctional beliefs (Obsessive Belief  
47  
48 Questionnaire-44; Obsessive Compulsive Cognitions Working Group, 2005), partial  
49  
50 correlations between the ICQ-EV and OC symptoms (Padua Inventory-Washington State  
51  
52 University Revision; Burns, Keortge, Formea, & Sternberger, 1996), controlling for beliefs,  
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revealed that inferential confusion was independently associated with the OC total score, obsessional thoughts about harm, and checking and contamination (Aardema et al., 2010). Finally, like the ICQ, the ICQ-EV showed an adequate capacity to distinguish between OCD and anxious non-OCD participants (Aardema et al., 2010; Pozza et al., 2018).

Although there is evidence supporting the relevance of the inferential confusion construct, there is scarce research analysing this construct in cultural contexts other than North America. We have only been able to find one paper with an Italian sample (Pozza et al., 2018). The aims of the present study are: first, to analyse the factor structure and psychometric properties of the Spanish adaptation of the ICQ- EV; second, to further investigate whether the inferential confusion construct is significantly associated with obsessive-compulsive symptoms, taking into account the heterogeneity of OCD, and whether it explains symptoms beyond dysfunctional beliefs about thoughts; and third, to establish whether the inferential confusion construct, as measured by the ICQ-EV, discriminates between non-clinical and OCD clinical participants. Based on the previous literature, we expect: first, that the Spanish version of the ICQ-EV will show a one-factor structure with good psychometric properties; and second, that inferential confusion, as measured by the ICQ-EV, will explain OC symptoms, independently of their thematic content, beyond the role played by dysfunctional beliefs. Finally, we expect higher scores on the ICQ-EV, indicating higher inferential confusion, in the OCD group.

## Method

### Participants

The sample consisted of two groups. A detailed description of the demographic characteristics of both groups can be found in Table 1.

**Non-clinical Sample.** The non-clinical sample consisted of a group of 342 participants (76% female) with a mean age of 29.16 years (range [18-65];  $SD = 13.93$ ). The majority of



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2  
3 the participants were undergraduate students (64.3%), and the rest were community  
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5 volunteers. Most of the participants were single (71.6%), and 91.5% had finished secondary  
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7 level studies. Fourteen of the participants reported having been diagnosed with a  
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9 psychological disorder (three with panic disorder, major depression, or specific phobia; two  
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11 with dysthymia; one with generalized anxiety disorder or social phobia).  
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15 **Clinical Sample.** A group of 66 participants (52% female) with a primary diagnosis of  
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17 OCD (DSM-IV-TR, American Psychiatric Association, 2000) made up the clinical sample.  
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19 Their mean age was 34.74 years (range [18-63];  $SD = 9.78$ ), and half of them ( $n = 33$ ) were  
20  
21 married. Most of them (66.7%) had university education. Eighteen of the clinical participants  
22  
23 had one or more secondary comorbid disorders: general anxiety disorder ( $n = 5$ ), major  
24  
25 depression ( $n = 4$ ), hypochondriasis ( $n = 3$ ), social phobia ( $n = 3$ ), panic disorder ( $n = 2$ ), and  
26  
27 specific phobia ( $n = 1$ ).  
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### 30 Measures

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33 **Inferential Confusion Questionnaire Expanded Version (ICQ-EV; Aardema et al.,**  
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35 **2010).** The ICQ-EV measures the level of inferential confusion. Items are rated on a 6-point  
36  
37 scale ranging from 1 = *strongly disagree* to 6 = *strongly agree*. The ICQ-EV showed good  
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39 psychometric properties, as described in the Introduction section. The ICQ-EV was translated  
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41 into Spanish by one of the authors of this study. Afterwards, a native English speaker who  
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43 was bilingual in Spanish back-translated the Spanish version into English. The original  
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45 English version and the translation were compared, and discrepancies were discussed with the  
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47 primary author of the questionnaire until reaching an agreement. Wording of the items is  
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49 shown in Table 2. See the Spanish version of the ICQ-EV in the Appendix.  
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54 **Obsessive Beliefs Spanish Inventory-Revised (OBSI-R; Belloch et al., 2010).** This is  
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56 a self-report questionnaire designed to evaluate dysfunctional beliefs hypothetically related to  
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58 the maintenance and/or development of OCD. It consists of 50 items rated on a 7-point Likert  
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3 scale ranging from 1 = *absolutely disagree* to 7 = *absolutely agree*. Items are grouped in three  
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5 factors: Responsibility/Threat (15 items), Importance/Control Thoughts (22 items), and  
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7 Perfectionism/Uncertainty (13 items). Previous studies revealed moderate/high associations  
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9 between the OBSI-R and OC symptoms (OCI-R; Foa et al., 2002) and moderate associations  
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11 with depressive symptoms (Beck Depression Inventory; Beck & Steer, 1993). The OBSI-R  
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13 total score and subscales differentiate between clinical OCD participants and non-clinical  
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15 participants, and most of the subscales also differentiate between OCD and anxious patients.  
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17 However, no differences were found on the OBSI-R between OCD and depressed patients  
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19 (Belloch et al., 2010). The relevance, but not the specificity, of dysfunctional beliefs is  
20  
21 consistent with previous reports (e.g., Tolin, Worhunsky, & Maltby, 2006). In the present  
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23 study, the internal consistency (Cronbach's  $\alpha$ ) of the subscales for the non-clinical/ clinical  
24  
25 samples was .86/ .93 for Responsibility/Threat, .91/ .96 for Importance/Control Thoughts, and  
26  
27 .91/ .91 for Perfectionism/Uncertainty.  
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33 **Obsessive-Compulsive Inventory-Revised (OCI-R; Foa et al., 2002; Spanish**  
34 **version: Belloch et al., 2013; Fullana et al., 2005).** The OCI-R is a self-report questionnaire  
35  
36 that assesses distress associated with various obsessive-compulsive symptoms on six  
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38 subscales with three items each: washing, checking, ordering, obsessing, hoarding, and  
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40 neutralizing. It consists of 18 items with a 5-point Likert scale ranging from 0 = *Not at all* to 4  
41  
42 = *Extremely*. There is evidence supporting its convergent and divergent validity in clinical and  
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44 non-clinical samples (Foa et al., 2002; Fullana et al., 2005). In the present study, the internal  
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46 consistency for the subscales ranged from .59 (Neutralization) to .79 (Obsessing) in the non-  
47  
48 clinical sample, and from .78 (Obsessing) to .91 (Checking) in the clinical sample. This  
49  
50 moderate to high internal consistency is similar to what was reported in other studies with  
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52 Spanish clinical (Belloch et al., 2013) and non-clinical samples (Fullana et al., 2005).  
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**The Depression Anxiety Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995; Spanish version: Daza, Novy, Stanley, & Averill, 2002).** The DASS-21 is a self-report questionnaire designed to measure the negative emotional states of depression, anxiety, and stress. It consists of 21 items with a 4-point Likert scale ranging from 0 = *did not apply to me at all* to 3 = *applied to me very much, or most of the time*. The DASS-21 has adequate psychometric properties and good convergent and discriminant validity when compared to other validated measures of depression and anxiety (Henry & Crawford, 2005). In the present study, the Depression (seven items) and Anxiety (seven items) scales are used. The internal consistency for Depression was .87 in the non-clinical sample and .89 in the clinical sample; and for Anxiety, it was .72 and .93, respectively. This internal consistency is similar to what was reported in other studies using the DASS-21 in Hispanic populations (Daza et al., 2002; Román, Santibáñez & Vinet, 2016).

### **Procedure**

For the non-clinical sample, students attending the 4<sup>th</sup> year of the undergraduate Degree in Psychology at Universitat de València (Valencia, Spain) were invited to participate in a study. While 175 students completed the ICQ-EV, 55 students completed the entire set of paper-and-pencil questionnaires (described above) during a training session on the purpose and procedure of the research. These 55 students recruited 129 community participants by inviting other people in their social network to participate in the study, and the students received course credit for their recruitment efforts. Seventeen participants were excluded due to missing data on any of the items on the questionnaires. Thus, the final sample was composed of 342 participants. In addition, seven participants did not complete the OBSI-R, although the decision was made to include them in the final sample. All the participants met the following inclusion criteria: age between 18 and 70 years, ability to read and understand the instruments, and the absence of any self-reported organic mental disorder, intellectual

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3 disability, or history of substance abuse disorders. In order to analyse test-retest reliability, the  
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5 129 community volunteers were invited to complete the ICQ-EV again two weeks later, and  
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7 98 responded to this request.  
8  
9

10 The clinical sample was recruited from private practice, announcements in a psychology  
11  
12 blog, and a Spanish OCD association (Asociación TOC Granada). Before being included,  
13  
14 volunteers were individually evaluated by one of the authors to obtain a full history and  
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16 examination. Intake assessment consisted of a diagnostic interview using the Anxiety  
17  
18 Disorders Interview Schedule for the DSM-IV: Lifetime version (ADIS-IV-L; Di Nardo,  
19  
20 Brown, & Barlow, 1994; Spanish translation: Morillo & Belloch, 1996). Information about  
21  
22 basic demographic data, medical conditions, and current/past psychological and  
23  
24 pharmacological treatment was also recorded. The evaluator also informed the patient about  
25  
26 the study's purpose and assessment procedure, and s/he asked for his or her explicit consent to  
27  
28 participate. Then, each patient was given the self-report questionnaires described in the  
29  
30 instruments section to be completed at home and returned within two weeks. Eight patients  
31  
32 did not complete the OBSI-R questionnaire. All the participants provided written informed  
33  
34 consent prior to completing the questionnaires. The study received the approval of the Ethical  
35  
36 Committee of the University (Universitat de València, H1458129873255).  
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#### 42 **Data Analysis**

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44 Statistical analyses were carried out using the statistical package SPSS for Windows v.  
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46 20 (IBM SPSS Inc., 2011) and MPlus 7.4 (Muthén & Muthén, 2015). First, we computed the  
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48 descriptive analyses of the ICQ items in the non-clinical sample: means, standard deviations,  
49  
50 skewness, and kurtosis. Second, again with the non-clinical sample, we analysed the internal  
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52 structure of the expanded version of the ICQ (30 items) by means of confirmatory factor  
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54 analysis. In these two steps, we restricted our analysis to the non-clinical sample, given that  
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56 the small sample size of the clinical sample would lead to very unstable results. In line with  
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3 Llorens-Aguilar et al. (2019), we chose confirmatory factor analysis instead of exploratory  
4 factor analysis because it makes it possible to include correlated uniqueness in the model. If  
5 no correlated uniqueness is included in the model, the model fit and estimated parameters are  
6 equivalent for both techniques in unidimensional models. Thus, confirmatory factor analysis  
7 offers the option of including more parameters than in exploratory factor analysis, if needed,  
8 with no drawbacks if not. Confirmatory factor analysis (without correlated uniqueness) and  
9 exploratory structural equation models are equivalent for unidimensional models. Given the  
10 expected floor effect on several of the ICQ-EV items, which implies a high departure from  
11 normality (e.g., "I sometimes cannot tell whether all the possibilities that enter my mind are  
12 real or not"), we treated the responses as categorical (WLSMV estimator in Mplus).  
13  
14 Goodness-of-fit was assessed for all the derived models, using the common cut-off values for  
15 the fit indices (Hu & Bentler, 1999): CFI and TLI with values greater than .95 and RMSEA  
16 less than .06 were indicative of satisfactory fit. Third, we computed the reliability: (a) internal  
17 consistency, computed with Cronbach's alpha, and (b) test-retest correlation. Fourth, in order  
18 to explore the associations between the inferential confusion construct and obsessive-  
19 compulsive related constructs and symptoms, we computed Pearson correlations between the  
20 ICQ-EV and OBSI-R scales, the OCI-R scales, and depression and anxiety scales from the  
21 DASS-21, for the non-clinical and clinical samples separately. Fifth, in order to explore  
22 whether the inferential confusion construct is significantly associated with obsessive-  
23 compulsive symptoms, beyond the role played by dysfunctional beliefs about thoughts, we  
24 conducted regression analyses in the non-clinical sample, with the total score on the OCI-R as  
25 dependent variable. In step 1, we controlled the influence of the DASS-Depression and  
26 DASS-Anxiety variables. In step 2, we introduced the OBSI-R subscales as predictors, and in  
27 step 3, we introduced the ICQ-EV. We repeated the same process for each of the OCI-R  
28 subscales as dependent variables. Sixth, to measure whether the inferential confusion

construct discriminates between clinical and non-clinical samples, we used Welch's *t* test analysis to compare the ICQ-EV scores of OCD clinical and non-clinical populations (Welch's test should be preferred over Student's test; Zimmerman, 2004). We also computed this difference when controlling for sociodemographic information. In this regard, we also tested the discrimination validity by analysing the area under the curve (AUC) through receiver operating characteristic (ROC) analyses of the ICQ-EV and other assessed constructs.

## Results

### Item Descriptors, Internal Structure, and Reliability of ICQ-EV

Item descriptors are presented in Table 2. The items on the ICQ-EV presented low means in the non-clinical sample ( $M_{mean} = 2.22$ , range [1.58, 3.03]). On average, data presented (mild) positive skewness ( $M_{sk} = 1.02$ , range [0.27, 2.16]) and kurtosis ( $M_k = 0.42$ , range [-0.93, 4.43]).

In order to analyse the factor structure of the ICQ-EV, a factor analysis was conducted in the non-clinical sample. The unifactorial model found in previous studies was tested, and it obtained goodness-of-fit values near the conventional cut-off values, although slightly worse than expected for TLI and RMSEA,  $\chi^2(405) = 1044.2$ ;  $p < .001$ ; CFI = .950, TLI = .947, RMSEA = .068. Items showed high loadings,  $M_{loading} = .72$ , range [.58, .81] (see Table 2).

The internal consistency, calculated with Cronbach's alpha, for the ICQ-EV was .95. Test-retest correlation ( $n = 98$ ) was .88, and the retest internal consistency was .97.

### Associations Between ICQ-EV and OCD Symptoms, Depression, and Anxiety

Zero-order correlations between the ICQ-EV and the remaining variables are presented in Table 3. Regarding the non-clinical sample, the ICQ-EV showed medium to high significant associations with every variable included: anxiety, depression, OCD symptoms, and OCD beliefs ( $r$  range [.33, .59]). However, a different pattern was found in the OCD

sample ( $n = 66$ ). Inferential confusion was significantly and positively associated with OCI-R Obsessing and Ordering, DASS-21 Depression, and the OBSI-R subscales ( $r$  range [.27, .44]). For the remaining variables, OCI-R Washing, Hoarding, Checking, and Neutralizing subscales, and DASS-21 Anxiety, correlations were non-significant ( $p > .05$ ).

### Hierarchical Regression Analyses

Regression analyses were carried out in order to predict OCD symptoms measured by the OCI-R. In the first step, the DASS-21 Depression and Anxiety subscales were entered, and in step 2, the OBSI-R subscales were entered, followed by entering the ICQ-EV total score in step 3. Table 4 presents the explained variance for each step, the change in explained variance, and the standardized coefficients for the third step in each regression. In predicting OCI-R Washing symptoms, the OBSI-R added 13% in the second step, whereas the ICQ-EV added a further 3% in the third step, thus emerging as the only significant predictor. The same pattern was observed for OCI-R Obsessing and Checking, with the second step (OBSI-R) accounting for 8% and 13%, respectively. The ICQ-EV was the only significant predictor in the third step, accounting for 13% and 5% of the variance. Regarding OCI-R Hoarding, the second step explained 12% of the variance, whereas the third step accounted for 7%, and three significant predictors appeared: DASS-Anxiety, OBSI-R Responsibility-Threat, and ICQ-EV. Finally, for OCI-R Ordering and Neutralizing, the second step accounted for 23% and 7% of the variance, respectively, whereas in the third step, the ICQ-EV did not account for significant variance.

### Comparison of Clinical and Non-clinical samples on the ICQ-EV

The non-clinical group and the OCD patients were compared on the ICQ-EV, and significant differences emerged,  $t(88.46) = 17.68$ , Cohen's  $d = 2.43$ , with OCD patients, ( $M = 131.36$ ;  $SD = 27.64$ ) scoring higher than the non-clinical group ( $M = 66.32$ ,  $SD = 25.92$ ). Then, we checked whether the groups were equally distributed in the socio-demographic

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3 variables. Differences were found in age, sex, marital status, and level of studies ( $ps < .001$ ;  
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5 Table 1). However, even after controlling for sociodemographic variables, differences in the  
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7 ICQ-EV between non-clinical and OCD patients remained significant ( $p < .001$ ), and they  
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9 even increased from 65.04 points without additional variables to 71.46 when controlling for  
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11 the sociodemographic variables. When the ROC curve was analysed, the AUC was 0.96. For  
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13 comparison purposes, we computed the AUC for the rest of variables, and in all cases, the  
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15 AUC values were smaller (from AUC = .41 for OCI-R Hoarding to AUC = .94 for OCI-R  
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17 Obsessing).  
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### 21 Discussion

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23 The ICQ-EV is a self-report instrument that measures the level of inferential  
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25 confusion, a key construct considered relevant in developing and maintaining an inference-  
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27 based model of OCD (O'Connor & Robillard, 1995). Although a relatively large number of  
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29 studies have supported the relevance of this construct, as evaluated by the ICQ-EV, in OCD  
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31 symptoms (Aardema et al., 2010, 2018; Wu et al., 2009), few studies have compared  
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33 inferential confusion and dysfunctional beliefs in a cultural context different from North  
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35 America. Moreover, the ICQ-EV has demonstrated good psychometric properties in English  
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37 and French (Aardema et al., 2010) and Italian (Pozza et al., 2018), but no studies have  
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39 analysed its properties in the Spanish population.  
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44 The present study confirms our first hypothesis. The Spanish version of the ICQ-EV  
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46 showed optimal psychometric properties, with excellent internal consistency and stability.  
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48 This result is consistent with previous studies conducted in clinical and non-clinical samples  
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50 with internal consistencies ranging from .83 to .97 (Aardema et al., 2010, 2018; Poza et al.,  
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52 2018; Wu et al. 2009). The current study also reveals a strong one-dimensional structure with  
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54 high factor loadings across the entire item set, thus supporting the original structure (Aardema  
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56 et al., 2005, 2010).  
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3 Regarding our second aim of analysing the contributions of the inferential confusion  
4 construct, beyond dysfunctional beliefs about thoughts, to explain specific symptoms, the  
5 results were partially consistent with our hypothesis. Results showed that, although neither of  
6 the two cognitive constructs, inferential confusion or dysfunctional beliefs, was relevant in the  
7 prediction of all the specific OC symptoms, each construct made a unique contribution to  
8 specific OC symptoms. Specifically, inferential confusion emerged as the only significant  
9 predictor of Obsessing, Checking, and Washing OC symptoms, which are very common  
10 symptom dimensions in OCD. Moreover, inferential confusion made a contribution to  
11 explaining Hoarding symptoms, but it did not significantly predict Ordering or Neutralizing  
12 symptoms.

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26 The ICQ- EV predicted a substantial portion of the variance in Obsessing symptoms, a  
27 dimension that is cognitive in nature, which is consistent with previous research in clinical  
28 samples (Aardema et al., 2010). Regarding Checking, results are consistent with studies using  
29 the ICQ-EV (Aardema et al., 2018) in clinical and non-clinical samples (Wu et al., 2009) that  
30 reported a specific contribution of the ICQ-EV. In the case of Washing, results are consistent  
31 with studies supporting the relevance of inferential confusion in Washing OCD symptoms,  
32 and they also show significant unique relationships between inferential confusion and  
33 contamination symptoms (Aardema et al., 2005, 2006, 2010), although other studies have not  
34 supported the specific or shared contribution of the ICQ-EV (Aardema et al., 2018; Wu et al.,  
35 2009). It is important to note that previous research did not test the predictive power of  
36 inferential confusion in hoarding symptoms, and so this is the first study to point out its  
37 relevance. Recently, in other studies, the presence of hoarding symptoms in OCD has been  
38 associated with more severe OCD symptoms and autism characteristics (Boerema, Boer, van  
39 Balkom, Eikelenboom, Visser, & van Oppen, 2019). Finally, the ICQ-EV did not account for  
40 significant unique variance in Ordering and Neutralizing, although previous research showed  
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3 that the ICQ contributed to the prediction of VOI-Just Right symptoms (Aardema et al.,  
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5 2018).

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8       Regarding the belief domains, although they showed medium associations with all the  
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10 OCD symptoms in both the clinical and non-clinical samples, in the regression analysis, once  
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12 the ICQ-EV was introduced, the OBSI only predicted Hoarding and Ordering OC symptoms.  
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14 Specifically, Responsibility/Overestimation of Threat predicted Hoarding symptoms, and  
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16 Perfectionism/Intolerance to Uncertainty was the unique predictor of the Ordering symptoms.  
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18 This is consistent with other studies showing that Perfectionism/Intolerance to uncertainty is  
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20 especially relevant in explaining Symmetry/Order symptoms (Julien, O'Connor, Aardema, &  
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22 Todorov, 2006; Tolin, Brady, & Hannan, 2008; Wheaton, Abramowitz, Berman, Riemann, &  
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24 Hale, 2010). It is surprising that Importance/Control of Thoughts did not account for the  
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26 Obsessing symptoms after the ICQ-EV was entered in the final equation, given that previous  
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28 research has supported its relevance (Wheaton et al., 2010).

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33       The fact that inferential confusion did not emerge as a significant unique predictor of  
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35 all the OC symptoms is consistent with previous findings (Aardema et al., 2005, 2006, 2018)  
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37 and with the hypothesis that obsessive-compulsive beliefs stemming from the inferential  
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39 confusion process are associated with the occurrence of obsessive doubt and distorted  
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41 appraisal of the obsessive doubt or obsessions reinforcing the OC symptoms (Clark &  
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43 O'Connor, 2005). However, inferential confusion was a significant unique predictor of what  
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45 are often considered the most common symptom domains in OCD, with the exception of  
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47 ordering. Perhaps Ordering and Neutralizing were not predicted by the ICQ-EV because the  
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49 ICQ-EV does not measure aspects of inferential confusion that are more relevant to some  
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51 specific OCD subtypes, such as Ordering, or because the OCI-R does not accurately appraise  
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53 them. Furthermore, this result could indicate that OCD is a heterogeneous disorder (e.g.,  
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55 García-Soriano, Belloch, & Morillo, 2008; Haslam, Williams, Kyrios, McKay, & Taylor,  
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2003; Ravindran et al., 2019), and that different variables could be relevant for different OCD presentations. Dysfunctional beliefs may play a more relevant role in these Ordering contents. If this is the case, different therapeutic approaches (i.e., based on the dysfunctional reasoning process versus beliefs), or a combination of them, could help to better treat each obsessional presentation because patients frequently present obsessions with different contents. It is also important to note the moderate relationships between inferential confusion and dysfunctional beliefs in the clinical sample, and with Importance/Control Thoughts and Perfectionism/Intolerance to Uncertainty in the non-clinical sample. These results are consistent with previous research (Aardema et al., 2005, 2010). However, inferential confusion, as measured by the ICQ-EV, is distinct from dysfunctional beliefs measured by the OBQ or the OBSI-R, and it is independently related to most obsessive-compulsive symptoms (Aardema et al. 2006).

Regarding our third aim, the Spanish version of the ICQ-EV discriminated between the non-clinical and OCD clinical populations, as hypothesised based on previous research (Aardema et al., 2010). Patients with OCD scored higher than the non-OCD group, with extremely large differences, and these differences even increased slightly when controlling for sociodemographic variables. The ICQ-EV showed excellent discriminatory power when analysing the AUC, which was higher than what was reported in the Italian version of the questionnaire (Pozza et al., 2018; AUC=0.79) and the largest of all the variables included.

The current study has some limitations. The psychometric properties and regression analyses are based on non-clinical data, and although such samples have demonstrated their usefulness in OCD research (Abramowitz et al., 2014), a larger clinical sample to replicate these analyses would have been preferable. In addition, the clinical diagnosis was made based on DSM-IV criteria and not on the more recent DSM-5, although there are no significant changes in terms of the OCD diagnosis. The study includes a small clinical sample; future

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3 studies could extend this sample in a way that allows us to analyse the relationship between  
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5 inferential confusion and the heterogeneity of obsessive contents, taking into account the  
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7 patient's main symptom subtype. We used the OCI-R (Foa et al., 2002) to measure OCD  
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9 symptoms; however, this measure over-represents compulsions *versus* obsessions, and so  
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11 future studies could use other more suitable measures to investigate OCD symptom  
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13 dimensions. It would also be of interest to include clinical control samples in order to further  
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15 demonstrate the discriminant validity of the measure. Moreover, the current study is based on  
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17 questionnaire data that were answered at home by participants, and so a certain margin of  
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19 error due to possible misinterpretation of different items should be taken into consideration.  
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21 Future studies should analyse inference confusion using other instruments, such as interviews  
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23 or experimental methods, and targeting specific obsessions.  
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### 28 **Conclusions**

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30 The present study confirms that the Spanish ICQ-EV is an optimal measure for use in  
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32 the Spanish population. Moreover, results present further evidence of the relevance of the  
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34 inferential confusion process in OCD symptoms in a different cultural context from most of  
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36 the previous studies. At the same time, it highlights the need for further research on this  
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38 cognitive factor, taking OCD heterogeneity into account, because differences were found in  
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40 the role it played in different OCD symptoms. The ICQ-EV seems to be more relevant in  
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42 explaining Obsessing symptoms, although it also plays a role in the prediction of Checking,  
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44 Washing, and Hoarding. Results also suggest that inferential confusion and dysfunctional  
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46 beliefs play different roles in predicting different OCD symptoms. In this regard, more  
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48 research is required to study the real contribution of inferential confusion in explaining the  
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50 relationships between obsessive-compulsive beliefs and symptoms, as well as pointing to the  
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52 existence of other cognitive variables operating in OCD in addition to belief domains and  
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inferential confusion. Finally, the results show that OCD patients present higher scores than the non-clinical population on inferential confusion processes measured by the ICQ-EV.

For Peer Review

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Table 1. Frequencies, proportions, descriptive statistics, and differences between clinical sample and non-clinical sample in sociodemographic characteristics.

	Non-clinical sample <i>n</i> = 342	Clinical sample <i>n</i> = 66	<i>t</i> / $\chi^2$	<i>df</i>	<i>p</i>
Sex			16.38	1	< .001
<i>Women</i>	260 (76%)	34 (51.5%)			
<i>Men</i>	82 (24%)	32 (48.5%)			
Age	29.09 (13.93)	34.74 (9.78)	3.98	122.26	< .001
Level of studies			71.32	2	< .001
<i>Elementary</i>	29 (8.5%)	6 (9.1%)			
<i>Secondary</i>	245 (71.6%)	14 (21.2%)			
<i>High</i>	68 (19.9%)	46 (69.7%)			
level/University					
Marital status			18.38	2	< .001
<i>Single</i>	245 (71.6%)	31 (47%)			
<i>Married/partner</i>	82 (24%)	33 (50%)			
<i>Divorced/widow</i>	15 (4.4%)	2 (3%)			

*Note.* Age it is expressed as mean (standard deviation).

## SPANISH VERSION OF THE INFERENTIAL CONFUSION QUESTIONNAIRE 30

Table 2. Item descriptors and factor loadings of the ICQ in the non-clinical sample ( $n = 342$ ).

	<i>M</i>	<i>SD</i>	<i>SK</i>	<i>K</i>	Loadings
13. Sometimes every far-fetched possibility my mind comes up with feels real to me.	1.72	1.09	1.74	2.79	.81
20. I sometimes come up with far-fetched reasons why there is a problem or something wrong, which then suddenly starts to feel real to me.	2.12	1.28	1.12	0.57	.80
22. My imagination can make me lose confidence in what I actually perceive.	2.42	1.43	0.75	-0.47	.80
28. I sometimes come up with bizarre possibilities that feel real to me.	1.95	1.16	1.22	0.80	.80
21. I often cannot get rid of certain ideas, because I keep coming up possibilities that confirm my ideas.	2.81	1.40	0.27	-0.93	.79
25. Even the smallest possibility can make me lose confidence in what I know.	2.40	1.44	0.81	-0.29	.78
29. I often react to a scenario that might happen as if it is actually happening.	2.15	1.30	0.99	0.05	.78
23. A mere possibility often has as much impact on me as reality itself.	2.60	1.37	0.54	-0.65	.77
10. My imagination is sometimes so strong that I feel stuck and unable to see things differently.	1.93	1.22	1.48	1.80	.76
16. Even if I don't have any actual proof of a certain problem, my imagination can convince me otherwise.	2.48	1.43	0.72	-0.42	.76
26. I can imagine something and end up living it.	1.90	1.27	1.54	1.78	.76
15. In order to tell whether there is a problem or not I tend to look more for that which is hidden than what I can actually see.	2.56	1.40	0.61	-0.60	.75
19. Often when I feel certain about something a small detail comes to mind that puts everything into doubt.	3.03	1.48	0.32	-0.86	.75
14. I sometimes get so absorbed in certain ideas that I am completely unable to see things differently even if I try.	2.04	1.24	1.16	0.43	.73
17. Just the thought that there could be a problem or something wrong is proof enough for me that there is.	2.34	1.33	0.76	-0.35	.72
27. I am more often concerned with something that I cannot see rather than something I can see.	2.53	1.49	0.57	-0.83	.71
3. Sometimes certain far-fetched ideas feel so real they could just as well be happening	2.11	1.28	0.96	-0.19	.70
8. Certain disturbing thoughts of mine sometimes cast a shadow on to everything I see around me.	2.08	1.34	1.21	0.60	.70
24. Even if I have all sorts of visible evidence against the existence of a certain problem, I still feel it will occur.	2.02	1.23	1.10	0.29	.70
30. I sometimes cannot tell whether all the possibilities that enter my mind are real or not.	1.70	1.01	1.83	3.01	.69
7. I often connect ideas or events in my mind that would seem far-fetched to others or even to me.	2.11	1.26	1.12	0.46	.68
12. I often cannot tell whether something is safe, because things are not what they appear to be.	2.67	1.50	0.49	-0.90	.67
5. I can get very easily absorbed in remote possibilities that feel as if they are real.	2.53	1.48	0.71	-0.51	.66
6. I often confuse different events as if they were the same.	1.86	1.10	1.31	1.12	.66
4. Often my mind starts to race and I come up with all kinds of far-fetched ideas.	2.51	1.46	0.70	-0.61	.65
18. I can get so caught up in certain ideas of mine that I totally forget about everything around me.	2.07	1.32	1.22	0.66	.65
2. I sometimes invent stories about certain problems that might be there without paying attention to what I actually see.	2.25	1.36	0.91	-0.21	.64
11. I invent arbitrary rules, which I then feel I have to live by.	1.78	1.11	1.58	1.98	.64
1. I am sometimes more convinced about what might be there than by what I actually see.	2.33	1.34	0.80	-0.36	.62
9. I sometimes forget who or where I am when I get absorbed in certain ideas or stories.	1.58	1.08	2.16	4.43	.58

Note. *M* = mean; *SD* = standard deviation; *Sk* = skewness; *K* = kurtosis.

## SPANISH VERSION OF THE INFERENTIAL CONFUSION QUESTIONNAIRE 31

Table 3. Comparison between the non-clinical and clinical sample on study variables, and correlations between those variables and ICQ-EV.

	Descriptors and Reliabilities						Mean Comparisons				Correlations With ICQ-EV		
	Non-clinical sample			Clinical sample			<i>t</i>	<i>df</i>	<i>p</i>	<i>d</i>	AUC	Non-clinical	Clinical
	M	SD	$\alpha$	M	SD	$\alpha$						sample	sample
ICQ-EV	66.32	25.92	.95	131.36	27.64	.97	17.68	88.46	< .001	2.43	.96	—	—
OCI-R Washing	1.02	1.67	.78	3.26	3.93	.90	4.46	74.47	< .001	0.69	.64	.42**	.05
OCI-R Obsessing	1.59	2.30	.79	8.86	3.21	.78	16.82	92.53	< .001	2.60	.94	.58**	.27*
OCI-R Hoarding	3.20	2.82	.70	2.58	2.93	.83	-1.49	115.21	.139	-0.21	.41	.44**	.16
OCI-R Ordering	3.61	2.85	.79	3.41	3.32	.86	-0.43	104.84	.665	-0.06	.46	.39**	.30*
OCI-R Checking	2.16	2.36	.78	4.36	5.16	.91	3.34	76.04	.001	0.55	.61	.47**	.16
OCI-R Neutralizing	0.76	1.50	.59	1.89	2.94	.72	2.98	78.77	.004	0.48	.65	.33**	-.14
DASS Depression	9.88	3.21	.87	16.29	7.51	.89	6.65	73.25	< .001	1.11	.82	.58**	.30***
DASS Anxiety	8.90	2.26	.72	13.95	5.85	.93	6.78	71.49	< .001	1.14	.85	.47**	.22
OBSI-R R-T	3.12	1.03	.86	4.38	1.41	.93	6.25	79.97	< .001	1.02	.77	.59**	.44***
OBSI-R I-C	2.51	0.82	.91	3.77	1.45	.96	6.27	70.62	< .001	1.07	.76	.35**	.37**
OBSI-R P-U	3.19	1.25	.91	4.28	1.39	.91	5.27	92.73	< .001	0.82	.72	.44**	.44***

*Note.* ICQ-EV: Inferential Confusion Questionnaire-Expanded Version; OCI-R: Obsessive Compulsive Inventory-Revised (non-clinical sample:  $n = 167$ ; clinical sample:  $n = 66$ ); DASS: Depression Anxiety Stress Scale-21 (non-clinical sample:  $n = 167$ ; clinical sample:  $n = 65$ ); OBSI-R: Obsessive Beliefs Spanish Inventory-Revised (non-clinical sample:  $n = 160$ ; clinical sample:  $n = 58$ ); R-T Responsibility-Threat; I-C: Importance- Control Thoughts; P-U: Perfectionism-Uncertainty.

\* $p < .05$  \*\* $p < .01$ . \*\*\* $p < .001$



## SPANISH VERSION OF THE INFERENTIAL CONFUSION QUESTIONNAIRE 32

Table 4. Regression analyses in non-clinical sample predicting OCD symptoms.

	OCI-R Washing			OCI-R Obsessing			OCI-R Hoarding			OCI-R Ordering			OCI-R Checking			OCI-R Neutralizing		
	$\Delta R^2$	$\Delta F$	<i>p</i>	$\Delta R^2$	$\Delta F$	<i>p</i>	$\Delta R^2$	$\Delta F$	<i>p</i>	$\Delta R^2$	$\Delta F$	<i>p</i>	$\Delta R^2$	$\Delta F$	<i>p</i>	$\Delta R^2$	$\Delta F$	<i>p</i>
Step1	<b>.12</b>	<b>10.21</b>	<b>&lt;.001</b>	<b>.17</b>	<b>15.22</b>	<b>&lt;.001</b>	<b>.10</b>	<b>8.36</b>	<b>&lt;.001</b>	<b>.10</b>	<b>8.17</b>	<b>&lt;.001</b>	<b>.08</b>	<b>6.98</b>	<b>.001</b>	<b>.07</b>	<b>5.47</b>	<b>.005</b>
Step2	<b>.13</b>	<b>8.57</b>	<b>&lt;.001</b>	<b>.08</b>	<b>4.95</b>	<b>.003</b>	<b>.12</b>	<b>7.60</b>	<b>&lt;.001</b>	<b>.23</b>	<b>16.40</b>	<b>&lt;.001</b>	<b>.13</b>	<b>8.10</b>	<b>&lt;.001</b>	<b>.07</b>	<b>4.22</b>	<b>.007</b>
Step3	<b>.03</b>	<b>5.37</b>	<b>.022</b>	<b>.13</b>	<b>29.52</b>	<b>&lt;.001</b>	<b>.07</b>	<b>15.27</b>	<b>&lt;.001</b>	.01	2.61	.109	<b>.05</b>	<b>9.18</b>	<b>.003</b>	.02	2.68	.104
	<i>beta</i>	<i>t</i>	<i>p</i>	<i>beta</i>	<i>t</i>	<i>p</i>	<i>beta</i>	<i>t</i>	<i>p</i>	<i>beta</i>	<i>t</i>	<i>p</i>	<i>beta</i>	<i>t</i>	<i>p</i>	<i>beta</i>	<i>t</i>	<i>p</i>
DASS-D	0.10	0.98	.330	0.02	0.22	.821	-0.04	-0.35	.730	0.06	0.61	.540	-0.03	-0.29	.773	-0.02	-0.20	.844
DASS-A	0.00	0.03	.976	0.07	0.77	.442	<b>0.02</b>	<b>0.24</b>	<b>.023</b>	-0.02	-0.22	.829	0.03	0.30	.767	0.10	0.92	.361
OBSI-R R_T	0.04	0.29	.204	0.10	0.76	.450	<b>0.41</b>	<b>2.87</b>	<b>.005</b>	0.20	1.47	.144	0.22	1.50	.137	0.19	1.20	.231
OBSI-R I_C	0.12	1.28	.204	0.13	1.45	.149	-0.08	-0.81	.417	-0.07	-0.74	.460	0.03	0.34	.734	0.08	0.73	.466
OBSI-R P_U	0.18	1.45	.150	-0.16	-1.37	.172	-0.19	-1.57	.118	<b>0.32</b>	<b>2.75</b>	<b>.007</b>	0.04	0.31	.756	-0.02	-0.17	.868
ICQ-EV	<b>0.23</b>	<b>2.32</b>	<b>.022</b>	<b>0.50</b>	<b>5.43</b>	<b>&lt;.001</b>	<b>0.38</b>	<b>3.91</b>	<b>&lt;.001</b>	0.16	1.61	.109	<b>0.30</b>	<b>3.03</b>	<b>.003</b>	0.18	1.64	.104

OCI-R: Obsessive Compulsive Inventory-Revised; R-T: Responsibility-Threat; I-C: Importance-Control Thoughts; P-U: Perfectionism-Uncertainty; ICQ: Inferential Confusion Questionnaire D: Depression; A: Anxiety. Bolded predictors mean significant at  $p < .05$ . Predictors entered in Step 1: DASS; Step 2: DASS, OBSI-R; Step 3: DASS, OBSI-R, and ICQ-EV.

## Appendix.

## Spanish version of the Inferential Confusion Questionnaire expanded version

Por favor, valora tu grado de acuerdo o desacuerdo con las siguientes afirmaciones utilizando la siguiente escala:

1	2	3	4	5	6
Muy en desacuerdo	En desacuerdo	Algo en desacuerdo	Algo de acuerdo	De acuerdo	Muy de acuerdo

	1	2	3	4	5	6
1. A veces estoy más convencido de lo que podría haber ahí que de lo que en realidad veo.						
2. A veces invento historias sobre ciertos problemas que podrían darse sin prestar atención a lo que realmente estoy viendo.						
3. Algunas veces ciertas ideas descabelladas me parecen tan reales que podrían estar ocurriendo.						
4. A menudo mi mente empieza a correr y me surgen todo tipo de ideas descabelladas.						
5. Puedo quedarme fácilmente absorto en posibilidades remotas que vivo como si fueran reales						
6. A menudo confundo situaciones diferentes como si fueran la misma.						
7. A menudo relaciono ideas o situaciones en mi cabeza que resultarían descabelladas para cualquier otra persona, incluso para mí.						
8. A veces, ciertos pensamientos perturbadores ensombrecen todo lo que me rodea.						

## SPANISH VERSION OF THE INFERENTIAL CONFUSION QUESTIONNAIRE

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1	2	3	4	5	6
Muy en desacuerdo	En desacuerdo	Algo en desacuerdo	Algo de acuerdo	De acuerdo	Muy de acuerdo

9. A veces olvido quién soy o dónde me encuentro cuando me quedo absorto en ciertas ideas o historias.						
10. A veces mi imaginación es tan fuerte que me bloqueo y soy incapaz de ver las cosas de otra forma.						
11. Invento reglas arbitrarias a través de las cuales siento que tengo que vivir.						
12. A menudo no puedo decir si algo es seguro porque las cosas no son lo que parecen ser.						
13. A veces todas las posibilidades descabelladas que pasan por mi cabeza me parecen reales.						
14. A veces me quedo tan absorto en ciertas ideas que soy totalmente incapaz de ver las cosas de forma diferente, aunque lo intente.						
15. Para decir si hay o no un problema tiendo a buscar más lo que pudiera ser que lo que en realidad ocurre.						
16. Aunque no tenga evidencias reales de un problema concreto, mi imaginación puede convencerme de lo contrario.						
17. La mera idea de que podría haber un problema o de que algo va mal, para mí es prueba suficiente de que lo hay.						
18. Puedo quedarme tan atrapado en algunas de mis ideas que llego a olvidarme de todo lo que me rodea.						
19. A menudo, cuando estoy seguro/-a de algo, me viene algún pequeño detalle a la cabeza y me hace dudar de todo.						

## SPANISH VERSION OF THE INFERENTIAL CONFUSION QUESTIONNAIRE

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1	2	3	4	5	6
Muy en desacuerdo	En desacuerdo	Algo en desacuerdo	Algo de acuerdo	De acuerdo	Muy de acuerdo

20. A veces llego a tener razones descabelladas sobre el porqué de un problema o de algo que no vaya bien y de repente esas razones empiezan a parecerme reales.						
21. A menudo me resulta imposible deshacerme de ciertas ideas porque no dejo de pensar en posibilidades que las confirman.						
22. Mi imaginación puede hacer que pierda confianza en aquello que realmente percibo.						
23. A menudo una mera posibilidad me impacta tanto como la realidad en sí misma.						
24. Incluso teniendo todo tipo de pruebas en contra de la existencia de un problema en concreto, sigo sintiendo que ocurrirá.						
25. Incluso la más mínima posibilidad puede hacerme perder la confianza en lo que sé.						
26. Puedo imaginar algo y acabar viviéndolo como si fuera real						
27. A menudo me preocupo más con algo que no puedo ver que con algo que sí puedo ver.						
28. A veces me vienen a la cabeza posibilidades raras que siento como reales.						
29. A menudo reacciono ante una situación que podría ocurrir como si realmente estuviera ocurriendo.						

SPANISH VERSION OF THE INFERENTIAL CONFUSION QUESTIONNAIRE

36

1	2	3	4	5	6
Muy en desacuerdo	En desacuerdo	Algo en desacuerdo	Algo de acuerdo	De acuerdo	Muy de acuerdo

30. A veces no puedo decir si todas las posibilidades que me vienen a la cabeza son reales o no.						
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For Peer Review

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