WHEN OBSESSIONS ARE NOT BELIEFS: SOME PSYCHOPATHOLOGICAL-GROUNDED OBSERVATIONS ABOUT PSYCHOTHERAPY WITH SEVERE PHOBIC-OBSESSIVE PATIENTS

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I. NOSOLOGY AND ESSENTIAL PSYCHOPATHOLOGY

Historical antecedents

The conceptualization of obsessive-compulsive disorders dates from the mid 19th century. From the definition of Guislain’s délire sans délire the French psychiatry has been fascinated by the apparent rationality of obsessions compared to other psychoses, so that Trelat used the definition of folie lucide and Legrand du Saulle (1875) those of folie or délire du doute. Only in the early 20th century Pierre Janet theorized an unification of various psychopathological dimensions from obsession and compulsive behaviours to panic-like symptoms, coining the concept of psychasthénie that anticipated the unitary phobic-obsessive model and locate these disorders outside the psychotic area.

In the German context classical authors focused on the effects of thought disorder, the compulsory features (Zwangs). Kräpelin wrote that this disorder was characterized by “irrepressible ideas and fears” resulting in a diminished freedom of will until to, in most severe cases, a complete destruction of mental freedom.

After the works of Binder (1936) and von Gebsattel, German clinical psychopathology has well defined the double structure of obsessive phobias that includes both a primary disorder of thought (Störungpsychismus), and a secondary, defensive component of the disorder (Abwehrpsychismus). The former includes the raising of an irra-
tional, intrusive, not repressible phobic ideas. This fear is disturbing and causes patient’s attempts to control and avoid it, that represent the second core aspect.

The question about the psychopathological genesis of phobias and obsession has been already argued in 19th and 20th century with a range of different theories, from the concepts of a defective “fonction du réel” (Janet) and of a weakening of will (Ribot), until to defence from guilt (Freud). Relationship between phobias and obsessions have been already admitted («Les anxieux, phobiques et obsédés – qui font partie d’une même famille clinique – sont parfois désignés sous le nom générique de psychasthénique» (Hesnard)); some French psychiatrists (Benon) did not distinguished at all between phobias and obsessions but only from “obsessions-phobies” and “obsessions-impulsions”. Other French authors (Lévy-Valensi) considered “phobies” only a variety of obsessions (“obsessions-craintes ou phobies”). Most of German psychopathologists admit a “phobic basis” of the obsessive phenomena (Zwangskrankheit) when not caused by organic or schizophrenic processes (von Gebsattel). Kurt Schneider locate the basis of obsession and phobias in the unsure personalities.

Before the publication of III edition (APA, 1980), also the American manuals included a diagnosis of phobic-obsessive neurosis as an in-between entity that describes a large amount of patients with mixed symptomatology.

Classical German psychopathology and the phenomenological contributions support a substantial continuity from phobic-obsessive to delusional experiences both on clinical and psychopathological levels (Stanghellini and Ballerini). A lot of intermediate phenomena between obsessions and delusions or acoustic hallucinations have been described with purely descriptive methods or in the context of the basic symptoms theory, supporting Kohler’s hypothesis or the delusional continuum. The loss of the feeling of the “belonging to I” of the ideation (Schneider, 1968) is at last the most important criterium that delimitate obsessions and delusional thoughts (Stanghellini and Ballerini). The same concept has been expressed by Hesnard fifty years earlier. He wrote that «les phobies et les obsessions […] sont comparables, au point de vue de leur objet, aux idées délirantes. Mais au lieu d’être comme celles-ci, acceptées, appropriées par le sujet et de devenir alors des convictions absolues, elles sont au contraire costamment et énergiquement repoussées par lui». Moreover – as stated von Gebsattel – the delusional patient feels him/herself threatened by other human beings, the phobic-obsessive from things and events.
When obsessions are not beliefs

Following von Gebsattel pioneeristic phenomenological research, Cargnello and Calvi demonstrated that the phobic obsessive themes are ideas that furnish reassuring content (in the stereotypal form of disgust and threat) to the de-structurating experience of deep anxiety. In his following phenomenological research Calvi states that the phobic object is unreal and essential in its nature, that is to say it cannot be confounded with psychological “real” objects. The phobic-obsessive is a painful prisoner of a magic illusion (von Gebsattel).

These so-called “historical studies” witness the deep understanding of psychopathological phenomena both in pre- than in post-therapeutical age, and claim both the need to reconsider phobias and obsessions inside the same disorder, both the need to pay a deep attention when we approach phobic-obsessions from a psychotherapeutic point of view.

More recent contributes

According to DSM III and following (DSM IV TR, APA, 1994) obsessions are defined as «recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. The thoughts are not simply excessive worries about real-life problems; the person attempts to ignore or suppress such thoughts or to neutralize them with some other thought or action; the person recognizes that the obsessional thoughts are a product of his or her own mind (not imposed from without as in thought insertion)». A phobia otherwise is defined as «marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation».

We aim to focus on a clinical group in which the overlap is evident. These patients experience fears, in form of obsessions, specific objects and situations, whose occurrence is highly improbable in reality but actual for them, and their fears have the form of irrepressible recurrent thoughts.

Up to date OCD is a distinct DSM-IV-TR diagnosis, nevertheless it shows a significant comorbidity with other anxiety disorders as panic disorder, social phobia and specific phobias with a rate, respectively up to 54%, 42% and 46,5% (Crino and Andrews; Rasmussen and Eisen). Both phobic and obsessive patients show avoidant behaviour (Biondi and Di Fabio), an increased subjective distress (Rachman and Hodgson) and autonomic nervous system arousal with similar physiological signs (Rabavilas and Boulougouris) when exposed to a feared stimulus. In these patients the fears are experienced as intrusive but not as senseless and have a ruminative quality.
Recent observations (Rapoport), consistent with the old classical works of Ribot (folie du doute), individuate the primary component of the disorder in doubts that don’t give rise to compulsive rituals, but rather to phobic avoidance (Aronson, 1990).

The severe phobic-obsessive patient cannot exclude that something dangerous or harmful has happened or can happen; they feel like a kind of certainty of doubt, equivalent to delusional certainty. The patients actualize potential dangers or eventualities. Any effort against the “potential” is destined to failure: no answer can be completely tranquilizing, no fight may be won against something that can happen, although with very low probabilities. “Very low” probabilities do not mean “impossible”. This is the main difficulty in the psychotherapy with these patients: the “potential” cannot be overcome with rational arguments.

(We suggest that phobic-obsessions, even when unchained by real events and psychological stressors, and when refer to specific biographical contents – that is to say when they are “derivable” –, often look like to be psychologically understandable, but really they are not, just like all others “psychotic” ideas.)

II. COGNITIVE PSYCHOPATHOLOGICAL CONTRIBUTIONS

Most of the recent psychopathological literature on phobic and obsessive pathologies has a cognitive background.

Rasmussen and Eisen (1990) suggest that intolerance to uncertainty may explain the difference between patients with obsessions and non clinical subjects. A significant amount of clinical and experimental evidences support the classical idea formulated by Freud in “Totem und Tabu” that guilt is a basic emotion with a major role in genesis of obsessions, an emotion often rooted in premorbid personality. Freud refers to obsessions as a defensive mechanism against an unconscious guilt derived from early life experiences meanwhile more recent authors proposed that a conscious guilt is associated to OCD as expression of an increased sensibility to personal responsibility. The concept of “inflated responsibility” has been introduced: it was defined as «the belief that one has power which is pivotal to bring about or prevent subjectively crucial negative outcomes. These outcomes may be actual, that is having consequences in the real world, and/or at a moral level» (Salkovskis, 1985). It has been empirically established that it plays an important role in the maintenance of symptoms (Rachman, 1995). According to other findings (Wroe and Salkovskis) the obsessive patients
attribute greater importance to *omission* error than *commission* error: to leave out the maximum effort to avoid a harm is equivalent to commit this harm or even worse, therefore the patient does not take in account the cost of acting the iterative behaviours to prevent the feared harm, cost that is the perpetuating of the disorder itself.

Mancini *et al.* argue that the cognitive core of obsessive psychopathology is, more than an inflated responsibility, a fear of the guilt, especially the *guilt for omission* and this clarify the fearful nature of the disorder and also the role of responsibility.

The phobic-obsessive patient may formally rightly estimate the probability of incur harmful consequences, if exposed to feared stimulus, but he cannot tolerate the possibility of incur such consequences for a personal omission, so that he must activate compulsion, rituals or avoiding behaviours. These emotional aspects impact on definitive probability esteem that becomes hypertrophic.

Another emotion that plays a significant role in phobic-obsessive is *disgust*. It is a basic emotion (Johnson Laird and Oatley) addressed to keep away dirt, excrement, body fluid and so on, with the probable evolutionistic aim to avoid incidental poisoning or contagion. An inflated disgust is frequently reported in *AIDS phobia* or other *infective illnesses phobias*, and in peculiar features of obsessive thought (Power and Dalgleish). In strict relationship with disgust and contagion avoidance are non logic or pre-logic reasoning modalities, known as magic thought. According with the “laws of sympathetic magic” (Frazer), contaminated things have the property of spreading the contagion simply by occasionally being in touch with other things, with a possible endless chain of passages (von Gebsattel): the progressive reduction of infective power is not evaluated. A thing that has been contaminated, remains a possible source of contamination regardless of the temporal decadence of infective power. For similarity (“like produces like”) a symbolic representation assumes the property of a real thing: i.e. a photography or painting of a person with infective disease is really contagious (Mancini and Gragnani, 2003). Moreover, in the magic thought can be found a concretization of thought, i.e. thinking to kill someone is equivalent to kill someone, thinking about having sex with an AIDS ill person *is like* acting or having acted this behaviours and so having taken the risk of the contagion. Freud argued that “omnipotence of thought” emerges in obsessive patients as in primitive cultures and childs. In the obsessive patient emotional intensity and affective resonance causes loss of interest for external reality and the result is that only what is perceived by thought gains significance (“Totem and Tabu”).
Cognitive works take distance from classical psychodynamic theories because they refer to conscious cognitive schemata, latent in any individual (so called beliefs), and not to unconscious material. They differ also from classical psychopathological conceptualization because these schemata are part of patient’s mind but they are latent, until a specific event activate them, so that they may be not consistent with personality traits. So obsessive patient are not necessarily scrupulous, diligent, moralist as phobic patient are not coward. Following standard cognitive theory, an event produces the activation of patient beliefs and cognitive schemata, relevant to fear of guilt or to responsibility, and trigger cognitive bias, avoidant behaviours and so on.

III. WHAT IS PSYCHOPATHOLOGICALLY SPECIFIC FOR PHOBIC-OBSSESSIONS?

An erroneous valuation of the risk may be considered just an incorrect deduction; proneness to guilt is a dimension that can be found from normal scrupulous and honest people to patients with severe depression. The association between the two abnormalities in the same thought process, and in a single individual, could be specific for this disorder.

Despite these considerations we still do not have a clear model of the primary thought disorder.

<table>
<thead>
<tr>
<th>Tab.1: The more frequent contents of phobic-obsessions</th>
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<tbody>
<tr>
<td>Skin spots, also very small and other aesthetic defects</td>
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<tr>
<td>Every places where medical assistance is not available (Agoraphobia)</td>
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<tr>
<td>Lighters, gas switches</td>
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<tr>
<td>Dirty things or bodies or hands</td>
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<tr>
<td>Drugs</td>
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<td>Needles</td>
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<tr>
<td>Knives</td>
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<tr>
<td>To be harmful for someone else; other little interpersonal faults</td>
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<tr>
<td>Infective diseases, especially venereal</td>
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<tr>
<td>To be perverse in sexual activities</td>
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<tr>
<td>To be abused in childhood</td>
</tr>
<tr>
<td>To be blasphemous</td>
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<tr>
<td>Death and especially funerary apparatus</td>
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Obsessive phobias are strictly related to *specific stimuli*, and the patients can tolerate their doubts about other topics, even really dangerous, just like healthy subjects. For example free climbers can be affected by needles phobias or even lifts phobia! Not all kinds of dangers are feared by these patients, but only *specific objects* and situation that, even very rarely, could be dangerous for personal health or safety (Tab. 1). The *specificity* of phobic-obsessive themes is a major feature of the disorder: their recurrence in a large number of patients is a clear proof of its trans-individual nature. However very often is a single event, in which the inflated responsibility plays a role, to unchain the symptomatology.

**Case 1**: We have observed for one years and half a 22 years old male patient who, after a talk with a member of an association of heroin addicted patients in therapy, refused to give them a contribution for AIDS medical research. At the end of the talk they had a handshake. The patient did not feel himself guilty or develop an obsession about his own denial of a generous gift, just like he did not develop a persecution delusion concerning the association. He developed a specific AIDS phobia.

In the premorbid personality features we found inflated responsibility as defined by Salkovskis (1999) but did not emerge neither experiences regarding the need to avoid illness nor the personal responsibility about contagion nor disgust sensitivity, nor a phobic attitude toward sex. Nevertheless the patient “selected” a specific contagious illness phobia from the innumerable guilt-related triggers for obsession.

Even if during the course of the disorder, it was possible to find that an inflated fear of guilt for omission and the magic thought, typically related to inflated disgust, contribute to the maintenance of compulsions, these emotional phenomena are not explicative of the sudden outbreak of this specific and typical phobic-obsession.

According to Jaspers definition, we could affirm that obsessive phobias are *derivable* from experiences of life but are not really *understandable*. They rise up much more like delusional intuitions than as thought processes in others anxiety disorders. In a recent work, from a constructivist perspective, Lorenzini and Sassaroli support the idea that obsessive thought is closer to psychosis than to neurotic thought, especially focusing on the belief of the ability to reach absolute certainty – of delusional intensity – by means of repeated controls. This conviction contributes to the impossibility to stop compulsions.
Summarizing: the delusional patient shows absence of criticism, complete adherence and absolute certainty referring his own ideas that are referred to external world and have not the feature of “belonging to I”. The obsessive-phobic doesn’t lack in criticism, his obsessions are intrapsychic, egodystonic but continue to belong to I; however he/she suffers of compulsive adherence to an incoercible doubt, that represents the equivalent of the delusional absolute certainty: the “doubt” is the psychotic feature of the phobic-obsessives (Tab. 2).

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<th>Phobias and Obsessions:</th>
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<td>are subjective, not dereistic in contents ↓</td>
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<td>The patients feel intense anxiety (up to panic) for the possibility that their irrepreensible ideas are real and true</td>
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| Delusions: do not belong to I, are objective, and dereistic in contents ↓ |
| The patients feel intense fear of something external to him/her that is believed real and true |

Obsessive thoughts vs delusional thoughts

Although the obsessive patient may be subjected to reality test, sometimes it is easier to treat a delusion than an obsession

Tab. 2

IV. CBT THERAPEUTICAL APPROACHES

In every therapeutic relationship reassurance is ubiquitarious and also the sharing of responsibility with the therapist is another aspecific therapeutic factor. Reassurance has a massive immediate effect but this is short-lasting (Lakatos, 1998). Following standard cognitive theory automatic thoughts, beliefs and cognitive schemata\(^1\) represent different

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\(^1\) Since Plato’s “Theaetetus” it is assumed that true knowledge is based upon justified beliefs, from whom knowledge itself is constructed by logic processes.
degrees of patient’s thought so the therapist must analyze and try to modify, with the patient, these different levels with the aim of a complete cognitive restructuring.

The most used approach in CBT for phobic and obsessive patients is exposure in his different manners. The specific technique for OCD is the Exposure and Response Prevention (ERP) therapy (Dèttore 2003). The patient is invited to cope the stimulus (exposure), trying hard not to carry out ritual or avoiding behaviours (response prevention). The exposure is always planned accurately during the therapy, it may be graduate or not graduate with a massive confrontation to the obsessive or phobic stimulus (flooding). The model is based upon the patient attempt to challenge or avoid the disturbing thoughts, expecting that the frequency and severity of intrusive thoughts will decrease as a consequence, according “pure” behavioural etiology hypotheses (Metzner; Rachman and Da Silva)

Other exposure techniques are sometime useful in order to reduce rituals but obviously they are ineffective in pure dubitative patients, with the exception of imaginative exposure (Dèttore). Actually therapists frequently apply ERP as a module in the framework of an intervention oriented to a broader change in patient mind.

The interventions may significantly differ according to different cognitive (less behavioural) theories. For Salkovskis many therapist try
to act on inflated responsibility, applying the “double standard” or similar techniques or challenging dysfunctional beliefs about personal responsibility. Frequent cognitive biases, common also in other anxiety disorder as catastrophic thought, with overvaluation of risk, are treated with specific intervention, as the “adding probabilities” (van Oppen and Arntz) that act directly on the evaluation of risk and responsibility.

V. PSYCHOPATHOLOGICAL BIAS
IN BEHAVIOURAL-COGNITIVE INTERVENTIONS

A major limitation of some models of intervention is the lack of a clear psychopathological background beside the psychological theory.

Most cognitive approaches are based upon the theory that a continuum exists between “normal” fears and phobias, “normal” senseless thoughts and obsession (Rachman and Da Silva; Salkovskis). We believe that, even if some surface features are similar, there is a substantial difference between most phobic-obsessive and non clinical subjects. The psychopathological core of Storungpsychismus is closer to delusion than to normal ideas and effectively it rise up during active phases of other disorders, for example bipolar disorder or recurrent depression. Especially in severe disorder, as in patients with poor insight or comorbid depression, difficulties are common in obtaining a real change with a psychotherapeutic intervention without pharmacotherapy. If in severe phobic-obsessive patients some feature of thought are more similar to delusion ideas than to reasoning in others anxiety disorders, an excessive emphasis on life events may lead to misunderstand the authentic nature of pathological obsessive phobias and create false links with life events or personal situations. The inner nature of primary thought disorder need to be further investigated, in order to clarify its cognitive, biological and psychopathological correlates.

We assume that some techniques may be successful, with a different degree, just because they are useful for the so-called abwerpsychismus, according to the idea that normalizing the intrusive ideas will reduce them.

Exposure techniques seem to refer to obsessive and phobic contents as real situations, risking the renewal of patient feared contents and misunderstanding the formal dubitative nature of morbid ideas. The corrective experience, possible in pure phobic patients, become very difficult in phobic-obsessive subjects, in which the continuous chain of doubts is the major therapeutic target.
These biases may explain some unsuccessful treatments as registered in over 50% of patients approached with classical CBT (Biondi and Di Fabio).

Acting on pathological inflated emotions as guilt or disgust may be useful in a subgroup of patients but totally ineffective in others. Usual approach does not take into account indeed the peculiar, delusional-like inconsistency of thought in some severe patients. It should be tested if obsessive phobias are really beliefs sensu stricto, following classical philosophical definition of beliefs, according to which they look more similar to “empty speech” (Berrios, 2001) or automatic (de Clerambault) and substantially meaningless brain production in psychosis or psychotic states (Schwartz).

VI. SPECIFIC PSYCHOTHERAPEUTIC PROCEDURES FOR PHOBIC-OBSESSIVE PATIENTS. SOME SUGGESTIONS

A basic step in the treatment of severe patients is the correction of the primary thought disorder. It can be achieved with an appropriate pharmacologic treatment in association with a well-defined psychotherapeutic attitude, and aims to minimize the sense of personal property of the obsessive thoughts (Schneider, 1968). If obsessive phobias are often delusion-like phenomena, they should be isolated from cognitive schemata of the patient without confuting them, remarking again and again that obsessive ideas are “brain productions”, not “I-productions” (Schwartz, 1996), and that their relationship with real events is not causal in their nature. The patient must be helped to take distance from them.

Construction of alternative hypothetic scenarios during the session, inviting the patient to challenge them similarly than in behavioural experiments, is a softer technique with analogous intents. Every experiment must be focused on reality tests, in order to create a broader range of concrete alternatives to pathological constructs of the patient, allowing the obsessive phobias to lose their affective resonance. As the obsessive phobias become more distant for the patient, they also become more susceptible to a critic process.

Confronting these patients by means of usual dialectical techniques, as the mere psychological confutation of pathological ideas is inadequate; more useful appears Socratic dialogue, that in his classical form is a method based on proposing question, with a subtle and accurately dosed irony. These questions evidence contradictions and paradoxes in
the opinions of the interlocutor until he perceives their internal inconsistence.

The typical obsessive thought emerges in the syntactical form of the dubitative “But if.”. In a pure dialectical setting is impossible to stop the endless chain of dubitative sentences, just because for the patient there are ever new doubts and his firm belief in omnipotent nature of thought requires continuous analysis in the nearly delusional credence of a possible rational solution to an irrational question.

Thanks to the rarity of phobic-obsessive feared events, their ironical confutation can be developed until a reductio ad absurdum, emphasizing their absurdity with hyperboles and exasperating the obsessive thoughts until their grotesque, comic or ridiculous consequences. These rhetorical strategy must be comprehensible to the patients, therefore his ability to understand irony is required. Using humour or paradox instead of annihilation of ideas, as suggested also by Mancini and Gragnani (2005), can also favourably act on the setting, changing the atmosphere from a dramatic one to a more relaxed situation, without reassuring directly the patient and consequently avoiding the risk to confirm as realistic the fears of the patient. Obviously this intervention requires a deep and confident relationship with the patient.

Another extremely refined technique is silence: if the classical psychoanalysis setting is unfit for obsessive patients, because the extremely silent and listening-prone attitude act negatively on these patients; however the silence, carefully considered, can be a powerful technical instrument for the therapist. In the dialectical setting represent the extreme answer to non-sense affirmations or insistent questions of the patients. Moreover the silence is a pause in which the patient is forced to confront himself with the inconsistencies of his reasonings.

Paradox and hyperbolis allow to by pass the classical syntactical constructions of obsessive patient.

An active monitoring of formal syntactical aspects of patient’s speech may be an important instrument to evaluate progress in therapy: a reduction of dubitative sentences (“But if.”) and raising of indicative mood in patient speech reflects a deep change in formal thought that represents a very favourable change.
VII. WHAT REALLY HAPPENS IN SUCCESSFUL PSYCHOTHERAPEUTIC TREATMENTS WITH PHOBIC-OBSESSIVE PATIENTS?

In most cases the treatment of the severe phobic-obsessive patient has not a clear and definitive therapeutic course, especially because patients requests for therapy are idiosyncratic. When phobic-obsession are not symptoms of depressive or bipolar mixed states, the “pure” patient shows wax and waning course and occasionally, often life-events-unchained more serious recurrences, so that he/she needs support in the long-term. Usually he/she is a good patient, compliant and regular in the session frequency.

A successful therapy is based, as usual, on a confident relationship and alliance between therapist and patient. At the beginning reassurance and standard CBT techniques are needed to reduce symptomatology; then a deeper intervention that tries to correct the core psycho-pathological aspects is needed; irony, Socratic method and the use of hyperbolis, as argued above, are recommended because strike at their cognitive roots the phobic attitude. Internalization of therapist’s attitudes, interventions and models configure a well functioning “cognitive transfert”.

Reinforcement sessions also long time after the recovery can be necessary. Sometime the clinical recurrence is preceded by re-appearance of aspects of formal thought disorder. The patient must be trained to recognize as pathological these aspects and contact the therapists earlier than possible.

Sporadic contacts with therapist by phone or e-mail are also encouraged in the maintenance phase.

VIII. APPENDIX: A CLINICAL SKETCH TO EXEMPLIFY THE UPPER SUGGESTED PSYCHOTHERAPEUTIC ATTITUDE AND MANOEUVRES

One of the authors (P.I.) has recently treated a clerk retired, sixty years old male patient, married, father of two sons.

His premorbid personality traits included perfectionism, intolerance to criticism, but no pronounced guilty feelings. He suffered of a short time anxiety episode ten years ago, and he was treated by an jungian psychotherapist and completely remitted. Since four years he suffers of erectile dysfunction with his wife, but he has successful intercourses
with prostitutes, taking Viagra, but not all the times. He doesn’t express regrets for this sexual behaviour.

Three months ago a prostitute from Puerto Rico persuaded him to use a dildo on his own body, but soon after he stopped this practice because of an intense pain. When at home he discovered some blood going out his anus and he almost immediately was caught from the idea of having contracted AIDS. The family doctor reassured him explaining that the risk was very very low, and suggested him to talk with the prostitute. She was very kind and reassured him just as the doctor, saying that she is healthy, that is subjected to medical and blood examination every six months, that she is used to sterilize the dildos and that, in any case, when she used it on him it was covered with the preservative. In the following days the patient was calling a lot of time again both the physician than the prostitute to be reassured further on. Then he called his first psychotherapist that heard him in the course of two session, referring his interpretations to the patients childhood.

When the patient asks a therapy to me, he is extremely troubled, he is obsessed from the fear to be contaminated with HIV III and broods for hours about the idea that “low risk” is not “no risk”, until he doesn’t demoralize himself judging himself to be a fool who spend all his time in senseless thoughts. He cannot avoid to show his medical examination asking if HIV III – test is completely confident, and then I surprise him saying: «No it isn’t at all» – indeed it is written even on the test report –; then I try to explain to him why I do not reassure him, differently from the person that he addressed before me. He looks like struck from my belief that searching reassurance about a “possible” risk is his own real problem: I explain to him that his obsessive fears looks like real but they aren’t; I continue saying that he doesn’t accept to miss a minimal control only because it is his way of living and he couldn’t forgive himself if he didn’t do it.

Summarizing, I try to show to him how the life events has stressed his usual thought functions unchaining a formally unendless sequence of fears and control attempts about something that looks life real and possible but really it is not. I deliberately avoid every sort of psychological interpretations (about sexual perversion and so on), but I stress that the fear to be perverse is a common idea in starting obsessive fears and controls (Dalle Luche, 1999). At last I prescribe a drug therapy.

In the second session I continue to explain the dysfunctional mechanism of the uncertainty about a possible risk, of the consequent phobic avoidance, the brooding following the lack of perception of the morbid nature of this thought processes. I avoid to establish if it is a “reaction” or a “micro-psychosis”, it doesn’t matter. What is really important is
that the patient understand that the psychotherapist knows very well his thought mechanisms, his mental idling, that is the real cause of his suffering. I quote some similar cases, stressing that what is happening to him is not so personal, and compelling him to take distance from the fearful contents of his brooding.

Avoiding reassurance is the only way to do not fall in the trap of the “But if.” questioning and to start a real (Socratic and paradoxical) dialogue with the patient looking for what is really disfunctioning in him.

REFERENCES

Rabavilas A., Boulougouris J.: “Physiological accompaniments of ruminations, flooding and thought-stopping in obsessive patients”. Behaviour Research and Therapy, 1974, 12, 239-244.
When obsessions are not beliefs


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