Doubts about me, doubts about you: a case of comorbid obsessive-compulsive and paranoid personality disorders

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Abstract

The case formulation and cognitive-behavior therapy of a patient whose pathology fulfills criteria for both obsessive-compulsive (OCD) and paranoid personality disorders (PPD) is described. Case formulation encompasses all the relevant cognitive, emotional and motivational factors underlying the disorders, emphasizing interactions between processes and strategies aimed at investigating and disconfirming feared scenarios, and reconstructing the ontogeny of pathological beliefs and themes in the patient's life history. The treatment targeted rumination and dysfunctional interpersonal cycles that maintained and reinforced pathology, promoting awareness, critical insights, risk acceptance and progressive decline of maladaptive control strategies. The challenges to the therapeutic alliance due to paranoid ideation towards the therapist and the relational strategies used to overcome them are also reported. The case offers clear indications about effective interventions that address both common and specific mechanisms involved in OCD and PPD, and provides observations that might foster future theoretical conceptualizations and research on the involvement of guilt, shame and humiliation in the two conditions.

Keywords: *Obsessive-compulsive disorder, Paranoid personality, Guilt, Humiliation, Risk acceptance.*

Sommario

Dubbi su di me, dubbi su di te: un caso di comorbidità tra disturbo ossessivo-compulsivo e personalità paranoide

L'articolo descrive la formulazione e il trattamento cognitivo-comportamentale del caso di un paziente affetto da disturbo ossessivo-compulsivo (DOC) in comorbidità con disturbo paranoide di personalità (DPP). La formulazione include tutti gli aspetti più rilevanti delle due patologie dal punto di vista

cognitivo, emotivo e motivazionale, mettendo in rilievo le interazioni tra processi e strategie utilizzate per indagare e disconfermare gli scenari temuti, e ricostruendo l'origine dei temi e delle credenze patogene nella storia di vita del paziente. Il trattamento è stato incentrato sui fattori di mantenimento della patologia, in particolare sulla ruminazione e sui cicli interpersonali disfunzionali, promuovendo consapevolezza, insight critico, accettazione del rischio, e un progressivo declino nell'utilizzo di strategie di controllo maladattivo. Vengono inoltre descritte le strategie relazionali messe in atto per superare le minacce all'alleanza terapeutica dovute all'ideazione paranoide verso il terapeuta. Il caso offre chiare indicazioni sugli interventi efficaci sia sui fattori comuni che su quelli specifici del DOC e del DPP, e fornisce osservazioni che possono stimolare future riflessioni teoriche e ricerche sul coinvolgimento della colpa, della vergogna e dell'umiliazione nelle due condizioni.

Parole chiave: *Disturbo ossessivo-compulsivo, Disturbo paranoide di personalità, Colpa, umiliazione, Accettazione del rischio.*

INTRODUCTION

Obsessive-compulsive disorder (OCD) is characterized by unwanted thoughts, images or urges (obsessions) that intrude the mind causing intense anxiety and distress, and by attempts to ignore, suppress or neutralize obsessions through repetitive behaviors or mental acts (compulsions: American Psychiatric Association, 2013). Several theoretical models emphasize how responsibility and guilt are involved in OCD symptomatology. More specifically, some kinds of obsessions are thought to be critically linked to scenarios in which the individual sees himself as responsible for actions that lead to catastrophic outcomes (e.g. explosion of the house building due to unrecognized gas leak: Salkovskis et al., 2000; Mancini & Gangemi, 2004; Rachman, 1993). Therefore, compulsions (e.g., checking) can be considered as attempts to prevent or remedy for responsibility of the terrifying events depicted by obsessions.

Experimental studies in which responsibility and guilt were induced in non-clinical subjects or OCD patients have shown increased scrupulosity and compulsive-like behaviors in high compared to low responsibility/guilt conditions (see De Putter et al., 2017 for a review).

Other subtypes of compulsions, such as washing and ordering, are supposed to be driven by disgust and fear of contamination (e.g., Olatunji, Lohr, Sawchuk, & Tolin, 2007), or by attempts to avoid/relieve a «not just right experience» (NJRE), that is, an undefined yet intense feeling that something is not quite as it should be (e.g., Coles, Heimberg, Frost, & Steketee, 2005). However, NJREs might not be unrelated to feelings of guilt, as guilt induction has been found to increase NJRE, but more significantly in individuals with high trait guilt (Mancini, Gangemi, Perdighe, & Marini, 2008). Moreover, there is evidence supporting an association between guilt (especially due to moral/religious transgressions) and disgust, as threatened morality has been shown to result in increased cleansing behaviors (Zhong & Liljenquist, 2006).

Indeed, some theorists have underlined the relevance of morality to OCD, proposing that obsessive anxiety is not centered on possible damage caused to other people (altruistic guilt), which is associated to sorrow, empathic proximity to the victim and compensative

action tendencies, but rather on moral violations (deontological guilt), which prompt regret and the tendency to confess wrongdoing and seek forgiveness (Mancini & Gangemi, 2004). In line with this view, there is evidence that deontological, but not altruistic guilt enhances OCD-like checking and washing behaviors (D'Olimpio & Mancini, 2014; Ottaviani, Collazzoni, D'Olimpio, Moretta, & Mancini, 2019; Giacomantonio, Salvati, & Mancini, 2019; for a review, see Gangemi & Mancini, 2017). Furthermore, different neural substrates for the two guilt types have been observed in both OCD patients (Basile, Mancini, Macaluso, Caltagirone, & Bozzali, 2014) and non-clinical samples (Basile et al., 2011). Intriguingly, neural areas responsive to deontological guilt (e.g., the insulae) are also critically involved in the experience of disgust, suggesting common underpinnings for physical and moral repulsion (Basile et al., 2011; Ottaviani et al., 2018). Indeed, boosting insular activity through anodal transcranial direct current stimulation (tDCS) leads to greater levels of subjective disgust and to judging vignettes with deontological themes (e.g., authority, fairness) as more morally wrong (Ottaviani et al., 2018).

There is compelling evidence that personality disorders are often comorbid with OCD. In particular, obsessive-compulsive, avoidant and paranoid personality disorders are among the most frequently diagnosed in OCD patients (Bejerot, Ekselius, & von Knorring, 1998; Torres et al., 2006; Brakoulias et al., 2017). While comorbidity between OCD and obsessive personality is easily predictable on the basis of common features, such as moral rigidity, scrupulosity and over-conscientiousness (Trincas, 2016), the association between OCD and personality patterns characterized by high interpersonal sensitivity, feelings of inadequacy and avoidance is less intuitive.

Early experiences of shame and humiliation seem to be crucial in the genesis of social anxiety and especially paranoia (Matos et al., 2013). The specific content of social fear differentiates shame-related psychopathologies. In social phobia, feelings of inferiority and inadequacy might be elicited even in the presence of people recognized as benevolent, whereas in paranoia the negative view of the self as subordinate and vulnerable is constantly coupled with a representation of others as malevolent, dominant, threatening (Matos et al., 2013). Therefore, the paranoid person fears and experiences active and intentional devaluation and humiliation, which on the one hand might be accepted in the light of the core negative view of the self, on the other hand might be vehemently refused, generating oscillations and conflicts between shame and anger that have been defined as the «paradox» of humiliation (Fernandez et al., 2015).

To sum up, OCD and paranoid personality are both characterized by intense fears (e.g., guilt, contamination, deception, derision) and the consequent attempts at preventing feared scenarios from happening (e.g., checking, washing, suspiciousness). Comorbidity of the two disorders is thus likely to generate a complex pattern of rigid and pervasive mental, behavioral and relational control, whose interactions maintain and exacerbate psychopathology. Such a complex pattern, and the therapeutic interventions used to address it, represents the reason for interest in the case described here, which illustrates how OCD and paranoia coexist in a young adult patient who fears both the possibility of being homosexual and partner infidelity, highlighting the relationships between beliefs, emotions, active goals and dysfunctional control strategies.

CASE PRESENTATION

Description of the symptomatology

Giacomo is a 22-year-old college student. He lives on his own, and his family includes father, mother and two elder sisters (26 and 24 years old respectively). His mother has a long history of mental health problems that have been attributed to bipolar disorder by the psychiatrists that treated her in the past years. Recurrent and severe depressive episodes emerge from Giacomo's report, describing how his mother helplessly spends most of her time in bed during these phases. The presence of manic or hypomanic episodes is doubtful, as intense and persistent irritability seems to be another prominent symptom, but it is not clear if irritability is mixed or alternated with depressed mood, and whether other diagnostic features (e.g. distractibility, grandiosity, agitation) occur. When Giacomo was 3 years old, his mother was hospitalized after a suicide attempt, and a foster home was given custody of him for approximately three months.

During the first session, Giacomo appears introverted, he looks downwards most of the time and rarely gazes at the therapist, sometimes he seems to struggle to find the words to say or to be very careful in choosing what to say. He is afraid of being homosexual, he reveals. This fear is suddenly and unwantedly activated by events or thoughts, and its onset was four years ago when he started a romantic relationship with his ex-girlfriend. In the attempt to prove his homosexuality wrong, Giacomo engages in mental imagery of homo- and heterosexual scenarios in order to compare the differential arousals elicited. He also monitors his arousal during sex to verify whether he really likes what he is doing.

Giacomo also reports to be constantly afraid of being deceived and manipulated by people, especially his girlfriend, Giovanna. In particular, he is worried about his girlfriend cheating on him with a friend of his, while the other friends of the group not only approve the betrayal, but also ridicule him for his unawareness. He generally expects people to harm or exploit him, and he also confesses he thought the therapist would be secretly in contact with Giovanna in order to convince him not to leave her (he is currently uncertain about his feelings for her). Even very specific elements of verbal and non-verbal behavior may trigger thoughts of malevolent intentions and/or deceit being real during vis-à-vis interactions or when he looks back at past events. When these thoughts appear, they elicit fear and anger, and Giacomo engages in mental rumination in the attempt to investigate and discover the truth, but usually ends up with exacerbated negative emotions that lead him to confront the involved people to ask for explanations. Whatever he is told in these situations is not convincing, and if the other person gets annoyed by his questions and accusations Giacomo might react with verbal and physical aggression, especially towards Giovanna. Sometimes the fears of being homosexual and deceived mix during social interactions: Giacomo gets convinced that people think he is gay, letting on about what they know through jokes and innuendo. He then starts to believe he is being observed and fooled by everyone, with intense feelings of shame that can turn into hostility.

On the basis of the problems reported during clinical assessment, and the results showed by a battery of psychological tests (see Table 1 in the Outcome Evaluation section),

a diagnosis of comorbid obsessive-compulsive (OCD) and paranoid personality disorders was made. The latter diagnosis was justified by the presence of 5 out of 7 criteria specified in the Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-V: American Psychiatric Association, 2013):

- Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him;
- Preoccupation with unjustified doubts about the loyalty or trustworthiness of friends or associates;
- Reluctance to confide in others because of unwarranted fear that the information will be used maliciously against him;
- Hidden demeaning or threatening meanings are found into benign remarks or events;
- Recurrent suspicions, without justification, regarding infidelity of sexual partner.

Precipitating and predisposing factors

The crucial event leading to the onset of Giacomo's current psychopathology was the start of the romantic relationship with Giovanna. The obsessive fear of being homosexual first appeared during his previous romantic relationship with a woman called Marta, which happened two years before Giacomo met Giovanna. The age gap between them (she was twenty years older) was a source of intense feelings of inadequacy for Giacomo, as he was seriously worried about his ability to be a good partner, especially in the sexual domain. He was jealous and controlling, and several episodes of physical abuse occurred. One day Giacomo happened to listen to a radio debate about violence against women, in which one of the speakers stated that «real men» would never beat up a woman as it is an unequal fight, the ones who do are actually equating themselves to women. This looked to Giacomo as a plausible explanation for his relational difficulties with women and his crushing sense of inadequacy: he was an unaware homosexual. Since the moment he listened to that «theory» of violence against women, the fear of being homosexual haunted his mind, and he initiated compulsive attempts to disconfirm it, through rumination and tests of his sexual arousal during both masturbation and intercourse. Importantly, the religious community Giacomo has been attending in the last three years enhances the current vulnerability to the obsessive fear, as the members view homosexuality as immoral and sinful.

Giacomo's relationship with his mother, and the impact of her mental disorder on family life, should be considered as a strong contributor to the subsequent development of Giacomo's psychopathology. Giacomo describes how the atmosphere at home was constantly tense, everyone had to be careful about what to say or do in order to preserve the mother's mood stability. Annoying her typically resulted in excessive anger reactions, possibly with physical punishment, followed by long periods of affective distance. In the worst cases, she was so mad and desperate that she threatened to harm herself or to commit suicide. Therefore, Giacomo sometimes had to face catastrophic consequences for acts he did not even recognize as disrespectful or harmful. Moreover, whoever was accounted responsibility for wrongdoing was harshly reproached by the other family members. Experiences of precocious responsibility, disproportionate punishment, and affect

deprivation as a punitive strategy have all been shown to constitute vulnerability factors for the development of OCD (Salkovskis et al., 2000; Tenore & Basile, 2018).

Giacomo's alertness, wariness and suspiciousness were and are still promoted during interactions with his parents. Giacomo reports that when he shares life events with his parents they use to make him aware of negative aspects and potential dangers that he had considered as negligible or even had not taken into account at all. This systematic manner of questioning the validity of his reasoning and evaluations, depicting people as competitive, shrewd and dangerous, and Giacomo as inferior, incapable and silly fostered Giacomo's negative view of his personal value and of people's intentions, as well as a moral view on suspiciousness as both necessary and normal.

Conceptualization (active goals, beliefs, emotions, maintenance mechanisms)

Giacomo's pathogenic beliefs about the self and the others clearly derive from his life history, especially in the family environment. On the one hand, Giacomo describes himself as weak, timorous and unimportant, and his problems, especially obsessive thoughts, strongly contribute to this negative view (secondary problem) as they are considered as abnormal, shameful and bizarre. On the other hand, people are seen as judgmental, malevolent, untrustworthy, disdainful.

Giacomo's fears of being homosexual and deceived are critically linked to the ultimate goals of preserving a sense of personal value, a good social image and proximity of other people. In line with this view, the unacceptable consequences of an actual infidelity would not be partner loss itself, but the unbearable shame of being considered as a fool by everyone around him. He believes that homosexuality would also expose him to derision, humiliation, and permanent social exclusion, as it is considered as a deviant and immoral condition (see the previous section). The functioning of Giacomo's OCD can be illustrated as follows (see Figure 1), analyzing an episode in which he accidentally watched two men kissing in a movie scene (Event). The schema is inspired by the OCD conceptualization proposed by Mancini and colleagues (2018), and represents an example of the reconstructions of problematic episodes that were carried out with Giacomo during sessions and assigned as homework between sessions (see Psychological treatment). The figure shows how the reaction (i.e., a vague bodily sensation) to the movie scene activates the fear of being homosexual and its implications (derision, humiliation etc.). It also highlights how Giacomo is motivated to make any possible effort to investigate his sexual orientation, with the aim to avoid the deontological guilt of having ignored signals potentially revealing a crucial aspect of his identity. More precisely, he believes that «knowing the truth» is essential not to live an «inauthentic life»: «I would be the first one to deceive myself» he explains. Unawareness would make him «twice a fool», he adds, exposing him not only to humiliation, but also to blame and reproach, thus enhancing feelings of guilt and preventing him from receiving any kind of support and consolation for the wrongdoing of others. Therefore, compulsions (Attempted Solutions (1) are also aimed at avoiding the possibility of being guilty and maintain psychopathology with their detrimental outcome. Rumination and mental imagery are ineffective, as any reassuring indication obtained from

them is susceptible to new doubt and criticism, in a virtually endless vortex that reinforces anxiety. In addition, obsessive thoughts and ruminations are negatively judged (Second Evaluation), reinforcing the fear of being homosexual, as the very fact of having obsessions is seen as proof of veracity of their content, and promoting further dysfunctional strategies (Attempted Solutions (2). More specifically, trying to suppress thoughts generates paradoxical outcomes, making thoughts more salient and vivid (the so-called *white bear* effect: Wegner et al., 1987). Avoidance of social relationships can only produce ephemeral tranquility while increasing loneliness, sadness and helplessness.

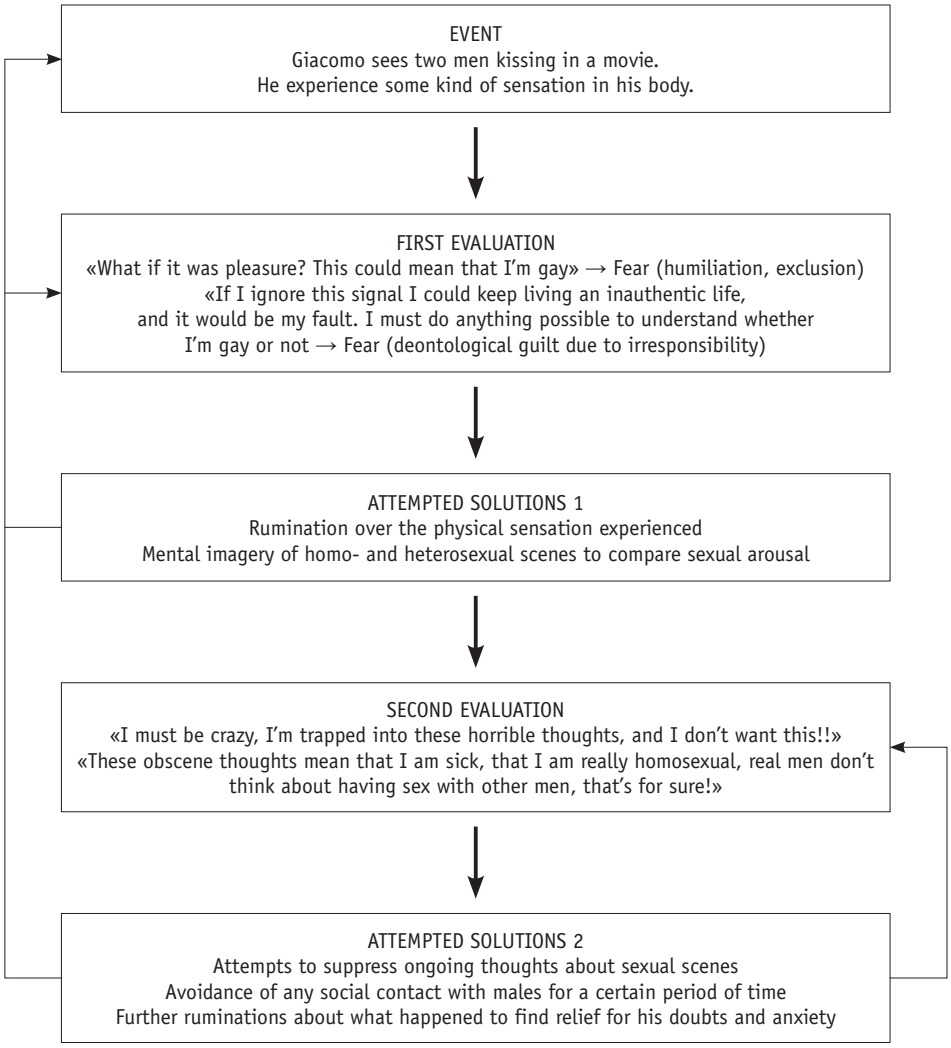

Fig. 1 Schematic model of Giacomo's OCD functioning.

Rumination is also a fundamental mechanism maintaining paranoid symptomatology. In order to highlight mental states and behaviors that characterize paranoid ideation, a specific episode reported during treatment will be described. During a conversation with a friend of his, Marco, Giacomo finds out that he is reading a novel that his girlfriend Giovanna had read too in the recent past. Giacomo wonders whether Marco and Giovanna had talked or even met unbeknownst to him. He starts considering when and where this might have happened, and he visualizes the scene of the two of them talking and laughing in a café. He feels jealousy, a mixture of fear and anger, bite his stomach and inflaming his face. He then seem to remember that Giovanna had mentioned Marco in a conversation some time ago, he tries to define the episode, and as he analyzes scenarios, hypotheses and connections between facts, the meeting between them becomes progressively more realistic, until he is pretty much convinced it really happened. He finds no other way to discover the truth but to ask Giovanna. He calls her and tells her he needs to talk urgently. Here is a brief reconstruction of their dialogue and of Giacomo's thoughts when they met:

Giacomo: (glum) Did you meet Marco recently?

Giovanna: (puzzled) No, I didn't meet him. Why? What is wrong with you?

Giacomo: Never mind. (*She didn't look confident…maybe «I didn't meet him» just means they did not arrange a meeting…what if they met accidentally? Yes, she could be hiding this…is she trying to fool me?*). Are you sure you didn't SEE him in any way?

Giovanna: (annoyed) No, I didn't see him! Wait a minute…did you come here to talk about THIS?! I can't believe it!

Giacomo: (*she's getting upset because I hit the spot…she's a liar!*)

What was meant to be reassuring becomes a confirmation of Giacomo's fears through the action of biased interpretations of Giovanna's words and reactions. He eventually feels insulted by Giovanna's astonishment when she realizes that their meeting was aimed at clarifying Giacomo's doubts, and his anger further rises until he attacks her by putting a hand on her face and pushing so hard she falls down. She starts crying. At this point a remarkable shift in Giacomo's mental states occurs. He feels sorry for having harmed his girlfriend, and he considers what he has done as awful and reprehensible, experiencing intense shame and guilt. He tries to approach her, but she warns him to keep away. When they both calm down, they discuss about what happened, and they agree that they should momentarily interrupt their relationship to allow solution of Giacomo's problems. When they separate, Giacomo feels extremely sad and guilty, and while walking home he wonders whether committing suicide would be the only option to put an end to his suffering.

To summarize, appraised possible deception generates anxiety and anger, which are managed through rumination in the attempt to investigate the plausibility of the feared scenario. This process is heavily biased towards the analysis of elements that confirm the feared hypothesis: as a result, the feared scenario is enriched with details and consistency, and the associated emotions are so intensified that they are experienced as intolerable. When he decides to confront Giovanna, a dysfunctional interpersonal cycle based on suspiciousness occurs (Nicolò & Nobile, 2003). His hostile and inquisitive attitude triggers insecurity, tension and irritation in his partner, which in turn reinforce perceived threat and

anger, giving rise to another interpersonal cycle based on aggression and its consequences (Nicolò & Nobile, 2003). Giovanna's pain after being hit turns off anger and aggressiveness to activate powerful feelings of guilt and shame, which motivate Giacomo's attempts to restore calm and proximity. He starts feeling helpless and hopeless in the face of his aggressive tendencies, believing he deserves refusal, exclusion and loneliness, and that is how the vicious circle is complete: his nuclear pathogenic beliefs and fears about his lack of personal value and his being undeserving of love are all strongly and painfully confirmed.

The underlying fundamental goals of being valorous and loved, and how value is instrumental to inspiring love, are well illustrated by recurrent mental fantasies reported by Giacomo. He often sees himself chasing and beating up a prowler that had attacked his girlfriend, receiving praise, admiration and gratitude by her and other witnesses. He can sense the pride, strength and power he would experience in such a situation. However, the discrepancy between the ideal self and the real self sharpen unworthiness, weakness, depression and isolation.

PSYCHOLOGICAL TREATMENT

Treatment was carried out in private individual setting with weekly sessions. It is still ongoing at the time this paper is being written, but frequency of sessions has been reduced to one every two weeks in the last seven months. Current total duration is two years. MP is the therapist, and AG provided supervision throughout the course. At the time the intervention began, MP was specializing in cognitive-behavior therapy at the School of Cognitive Psychotherapy (SPC, branch of Grosseto, Italy), and Giacomo was offered to take part to a special program of the school in which clients choose to be treated by a supervised student paying reduced fees.

The interventions were tailored to disrupt cognitive and interpersonal mechanisms maintaining psychopathology, as highlighted through case formulation. More specifically, OCD treatment was structured following the guidelines provided by Mancini and colleagues (2016, 2018) for the cognitive therapy of OCD. Globally, treatment was aimed at discouraging the use of compulsions in response to obsessive thoughts (Attempted Solutions 1), and in response to negative evaluations of OCD symptoms (Attempted Solutions 2) (see Figure 1). Furthermore, a non-judgmental and compassionate attitude towards OCD has been promoted to stop self-blame and shame deriving from criticism of obsessions and compulsions (Second Evaluation). As regards paranoid symptomatology, mental (i.e. rumination) and behavioral (i.e. suspiciousness, requests for reassurance) strategies to investigate the veracity of feared scenarios were targeted. Since obsessive and paranoid symptoms shared key functional mechanisms (rumination above all), associated emotions (e.g. guilt and humiliation), and both types of ideation were sometimes mixed in problematic episodes, their treatment was carried out in parallel through different and sequential stages.

1) Shared construction of an accurate understanding of the disorder (psychoeducation);
2) Development of critical insight and cognitive restructuring;
3) Fostering of risk acceptance as means to demotivate dysfunctional control strategies;
4) Comprehension and management of current and historical vulnerability.

1) The first phase of the therapy, which was partially initiated during clinical assessment, was dedicated to the construction of a diagrammatic model of the disorders starting from recent episodes reported by Giacomo. This collaborative procedure offers invaluable contributions to the creation of a solid therapeutic alliance, as the patient feels understood and represented in the therapist's mind, and becomes more motivated and confident towards the treatment (Romano & Trincas, 2018). This is even more important with a paranoid client like Giacomo, obviously. Moreover, the model constitutes not just a preparatory step for subsequent interventions, but rather a first and often very effective intervention itself, which normalizes emotional suffering clarifying that it derives from specific beliefs, involves fundamental goals and active problem solving strategies that can be changed to obtain more beneficial results (Romano & Trincas, 2018). In line with this view, Giacomo was both surprised and relieved to discover the underpinnings of his obsessive and paranoid disorders, and started to acquire critical distance from his thoughts, which was further promoted in the following stages of treatment. Pathological functioning was reconstructed according to the conceptualizations described above (see Conceptualization section), thus encompassing activating events, first evaluation, attempted solutions 1, second evaluation, and attempted solutions 2 for OCD, and dysfunctional interpersonal cycles for paranoia. A specific psychoeducation on functions, origins and correlates of emotion was also performed using the classic Antecedent/Belief/Consequence (ABC) model of the cognitive therapy (Ellis, 1962).

2) The knowledge of the schematic model of the disorders was the starting point for the development of the abilities to observe, recognize and distance problematic thoughts and behaviors, especially rumination, which was the main target. To develop these abilities, homework implying self-monitoring, ABC or schematic model reconstructions based on episodes (OCD- or paranoia-related) happened during the week were given. The reconstruction and comprehension of dozens of critical episodes through the assignments enhanced Giacomo's capacity to: promptly recognize warning signals and triggers; notice the appearance of disturbing thoughts and the elicited emotions; observe the onset, development and detrimental outcomes of ruminative processes; reflect on his own and others' mental states; formulate alternative explanations and solutions. Cognitive restructuring of obsessions was also carried out using specific techniques to normalize and favor effective management of unacceptable thoughts. For example, Giacomo was presented a list of intrusive thoughts typically reported by non-OCD people (adapted from Abramowitz, 2006), and was involved in behavioral experiments aimed at contrasting thought-action and thought-reality fusion, and at experiencing the paradoxical effects of attempted thought suppression (for a review, see Gragnani, Buonanno, & Saettoni, 2018).

3) This was an essential part of the treatment, with fundamental implications also for the management of critical moments in which paranoid ideation was directed towards the therapist (see the Outcome Evaluation section below). As previously shown, Giacomo's compulsions and paranoid investigations were aimed at preventing and/or discovering feared scenarios about being homosexual or betrayed. Inevitably, interrupting these strate-

gies would result in a rise of perceived threat, as the individual is dangerously not making any effort to control. Disinvestment in pathological control mechanisms can be favored by cognitive interventions focusing on accepting the risk of not trying to prevent threat. Acceptance can be fostered emphasizing three basic truths about prevention: it is not mandatory, it is terribly costly and counterproductive on balance, and it is impossible to accomplish with 100% certainty (Perdighe et al., 2018). Furthermore, an accepting state of mind is created when events and possibilities, even very undesirable and frightening ones, are reconciled with the natural order of things (Perdighe et al., 2018, Hayes et al., 2016). These general principles of acceptance oriented the discussion of Giacomo's strategies in response to obsessive and paranoid fears. First of all, it was underlined how persistent rumination, distrust and aggressiveness are exhausting and dangerous. Secondly, it was argued that despite countless and meticulous attempts, his ruminations did not allow him to clarify his doubts, so there was no reason to believe that it was useful and beneficial to keep them. Conversely, there was good reason to believe that such ruminations would never result in any kind of certainty, as any conclusion is provisional and susceptible to new revisions and doubts. Finally, Giacomo was invited to reflect on the naturalness and inevitability of shame and guilt in human social life, as well as the necessity to accept the risk of disappointment and betrayal in any significant relationship. When these issues were discussed, Giacomo realized how in the attempt to protect himself from humiliation (i.e., deception, derision) and guilt (i.e., irresponsibility for lack of effort to discover the truth), he was actually undermining some of his most important life goals, such as a successful college and professional career, having warm, caring and loving relationships with friends and partners. The real risk was to keep having that negative consideration of himself and the others, and this awareness motivated and supported him in tolerating exposure to OCD- and paranoia-related emotions without engagement in dysfunctional mental and behavioral solutions.

4) The work on predisposing factors was carried out in a more advanced phase of the treatment in order to further strengthen Giacomo's understanding of his problems and boost distancing and change. The knowledge of how his fears were rooted in his life's past events and relationships (especially with his mother) helped him in realizing the crucial links between pathogenic beliefs about the self and the others, fears of deception and homosexuality, and pervasive feelings of guilt and shame (Tenore & Gragnani, 2018). In particular, Giacomo acknowledged how affective neglect, verbal and physical aggression during his childhood were caused by his mother's psychopathology, and made him feel desperately unworthy of attention, care and love. When his mother was severely depressed, Giacomo thought his existence was not worth enough to make his mother want to live, and, as already described (see Precipitating and predisposing factors), he often believed he was responsible for her suffering. Shared remembering and discussion helped him to validate his emotions and unmet needs, and to overcome resentment, pain and guilt through the development of a compassionate view on himself (in past and present times) and his whole family. He faced the most recent episodes of his mother's illness with a calm, accepting and caring attitude, supporting his family as much as possible.

OUTCOME EVALUATION

Giacomo's commitment was very strong since the beginning of the therapy. However, in the early phases he really struggled to criticize and contrast his fears, especially that of being deceived, which inevitably and understandably was oriented towards the therapist at some point. Just as in his non-therapeutic relationships, even a single word was sufficient to activate alarm and suspiciousness. When this happened the first time, the look on Giacomo's face changed suddenly while the therapist was talking. When he stopped, the therapist was asked what he meant when he said that Giacomo «loved» Giovanna. Giacomo had become suspicious, and when this was realized the therapist experienced anxiety and bodily arousal in the stomach. The goal was to stay away from a dysfunctional interpersonal cycle and turn that occasion into a therapeutic opportunity. When asked the reason for that question, Giacomo hesitated before confessing he had thought the therapist was trying to manipulate and convince him that he was in love with Giovanna. For the first time he revealed he was not sure about his feelings towards her partner. He was irritated and alerted, but regret was also evident from his expression. The first step was validating Giacomo's emotions, inviting him to reflect on how they had emerged, and on the contrasting sensations elicited when manipulation was considered as true (anxiety, anger), and when he realized that he could be unjustly accusing another person (guilt, regret). «This is exactly what happens when you get suspicious in your life out of this room», the therapist then declared. «I feel anxiety right now, and I'm very concerned about any mistake I could make in interacting with you. On the basis of what we learned and shared about suspiciousness and vicious circles, I won't try to explain what I meant with my words. I know you might think that I'm only trying to save myself, but I'll take that risk, as I know that any other option would not be good for you. It's up to you now: are there alternative explanations for what I meant? Is it better for you to believe that I'm sincere and I'm here to support you, or that I am a malevolent manipulator? If you believe in the second possibility, I'll completely understand if you choose to interrupt our work and even go out right now». Fortunately, Giacomo decided to accept the risk of trusting the therapist. He was invited to share his doubts and suspicions during sessions. All the following episodes were openly and successfully discussed, ultimately leading to a solid confidence in the therapeutic relationship.

Despite several obstacles, especially in the early phases of treatment (poor insight, emotional and behavioral dysregulation, insecurities in the therapeutic alliance), Giacomo's improvements were constant and substantial in all the relevant psychopathological domains, as testified by the results of two follow-up assessments operated at one and two years after the treatment started (see Table 1). OCD, paranoid and depressive symptomatology all show significant reductions through time.

Table 1 – Results reported by Giacomo at initial and following assessments through the *Yale-Brown Obsessive-Compulsive Scale* (Y-BOCS), the *Beck Depression Inventory-II* (BDI-II) and the *Symptom Checklist-90-Revised* (SCL-90) questionnaires

TEST	SCALE	T_0	T_1 (1 year)	T_2 (2 years)
Y-BOCS	Obsessions	13	10	6
	Compulsions	13	11	4
	Total Score	26	21	10
BDI-II	Total Score (cut-off = 12)	17	10	6
	Factor 1: Affective-Somatic	11	4	3
	Factor 2: Cognitive	5	6	3
SCL-90	Somatization	0,42	0,5	0,25
	Obsessive-compulsive Disorder	1,40	1,30	0,90
	Interpersonal Sensitivity	1,00	1,56	0,67
	Depression	1,46	1,31	0,77
	Anxiety	1,80	1,30	0,70
	Hostility	2,33	1,17	0,67
	Phobic Anxiety	0,86	0,86	0,57
	Paranoid Ideation	1,83	1,33	0,83
	Psychoticism	0,80	1,60	1,50
	Global Severity Index	1,27	1,22	0,78

After two years of psychotherapy, Giacomo is about to get his bachelor's degree, and he is very excited about this great achievement. He has two stable groups of friends, one at the religious community he continues to attend, and another one made up of college friends. He enjoys company, feels accepted, respected and cared by people, and is capable of recognizing and managing obsessive or paranoid thoughts when they occur, with much reduced frequency and intensity. Sometimes he still experiences intense anxiety when physical sensations are elicited by obsessive intrusions, as he is afraid that physical sensations might represent stronger proof of homosexuality than thoughts or images. He has no girlfriend at the moment, and he desires a romantic relationship that is strikingly different form his previous ones. He feels ready to overcome jealousy and insecurity to find happiness and completeness in love. During the course of treatment he broke up with Giovanna because he realized he did not really love her, he felt somehow «forced» to be with her when she showed attraction towards him, as he believed he would not find another person who could love him like Giovanna did. Giacomo's positive change in his perceived value and his possibility of being accepted and loved just the way he is, is also expressed by his letting go of old fantasies about great endeavors to get admiration: «You know, so many times, when I was in bed at night, I dreamed about being a superhero…Now, it often happens to me to think that I'm just happy for the day I had».

CONCLUSIONS

The case illustrates how pathological control to manage obsessive and paranoid fears may intertwine, emphasizing the role of rumination as a common maintaining factor. It also describes how effective treatment has been founded on accurate and shared reconstructions of the cognitive, emotional and behavioral mechanisms involved. This laid the basis for the progressive abandonment of dysfunctional strategies through acceptance of perceived risk in the presence of obsessive or paranoid fear. Extreme and prolonged attempts to prevent threat were critically analyzed and revealed as useless, detrimental, tiring and ultimately impossible to achieve with complete certainty. Importantly, the discussion had global beneficial effects on Giacomo's fears. Finally, a crucial contribution to risk acceptance and overcoming of interpersonal suspiciousness has been achieved through successful management of paranoid ideation towards the therapist.

It is beyond the scope of the present article to discuss the commonalities between obsessive and paranoid motivations and themes that might explain comorbidity. However, some speculative observations can be made based on Giacomo's story. It has been highlighted how OCD patients, especially those with «repugnant» obsessions (i.e., intrusions concerning sex, violence, immorality), regard their symptoms as revealing despicable and unacceptable aspects of their identity (Rachman, 1997; Ferrier & Brewin, 2005). Giacomo is no exception: the mere presence of obsessive thoughts might prove his fear of homosexuality right, thus motivating his compulsive attempts at investigating. It has been described how these attempts are aimed at avoiding guilt for not having recognized an essential truth about the self. Homosexuality is feared as a repugnant and immoral condition, to which people would react with humiliation, contempt, derision, ostracism. Indeed, these are typical

punishments inflicted to moral violators (Brandt & Reyna, 2011). Interestingly, paranoid patients are also afraid of undergoing humiliation that is justified by negative qualities of the self (Fernandez et al., 2015, see the Introduction). Two paranoid mental states that critically differentiate on whether persecution is undeserved («Poor Me») or is a legitimate punishment («Bad Me») have been described (Trower & Chadwick, 1995). Therefore, it is possible that obsessive and paranoid patients share preoccupations about «bad» (e.g., dangerous, repulsive) aspects of the self that might lead to severe punishments, threatening essential social goals, such as reputation, attractiveness, inclusion, belongingness and rank (Gilbert, 2003). This might be a topic for future clinical and experimental research on the two disorders.

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