Rassegna

The role of the Retrospective Identification of Motivations and Inclinations in explaining obsessive beliefs

Il ruolo dell'Identificazione Retrospettiva delle Motivazioni e delle Inclinazioni nello spiegare gli assunti fondamentali del disturbo ossessivo-compulsivo

GHERARDO MANNINO[1]*
*E-mail: gherardo.mannino@libero.it

[1]Department of Mental Health, Azienda Sanitaria Locale Roma 1, Rome, Italy

SUMMARY. While psychopathological phenomena of obsessive-compulsive disorder (OCD) have been well described some time ago, instead there is still need for a deeper understanding of mechanisms underlying psychopathological phenomena themselves. About this, a recently proposed concept – the 'Retrospective Identification of Motivations and Inclinations' (RIMI) – seems to have a promising explanatory capacity about different aspects of obsessive-compulsive disorder. For example, as shown elsewhere, it appears to shed new light on the so-called 'fear of self' in OCD. In this paper, the role of RIMI in explaining OCD related 'belief domains' (responsibility/threat, importance/control of thoughts, perfectionism/certainty) will be discussed on the base of clinical cases. Moreover, within this discussion, the possible contribution of RIMI to the pathogenesis of both obsessions and compulsions will also be briefly outlined. Finally, a hypothesis about the probable genesis of this process will be advanced.

KEY WORDS: OCD, Retrospective Identification of Inclinations and Motivations (RIMI), OCD belief domains, responsibility/threat, importance/control of thoughts, perfectionism/certainty.

RIASSUNTO. Mentre i fenomeni psicopatologici del disturbo ossessivo-compulsivo (DOC) sono stati ben descritti ormai tempo fa, sussiste invece la necessità di una comprensione più profonda dei meccanismi che stanno alla base dei fenomeni psicopatologici stessi. A questo proposito, un concetto proposto di recente – l'Identificazione Retrospettiva delle Motivazioni e delle Inclinazioni (IRMI) – sembra possedere una promettente capacità esplicativa circa diversi aspetti del DOC. Per esempio, come illustrato altrove, esso sembra gettare nuova luce sulla cosiddetta 'paura di sé' un nel DOC. Nel presente articolo verrà discusso il ruolo dell'IRMI nello spiegare i 'domini di credenza' collegati al DOC (responsabilità/minaccia, importanza del pensiero/controllo del pensiero, perfezionismo/certezza), basandosi sulla presentazione di casi clinici. Inoltre, all'interno di questa discussione, verrà anche delineato il possibile ruolo dell'IRMI nella patogenesi sia delle ossessioni sia delle compulsioni. Infine, verrà avanzata anche un'ipotesi circa la possibile genesi di questo processo.

PAROLE CHIAVE: DOC, Identificazione Retrospettiva delle Motivazioni e delle Inclinazioni (IRMI), domini di credenze del DOC, responsabilità/sopravvalutazione del rischio, pensiero/controllo del pensiero, perfezionismo/bisogno di certezza.

INTRODUCTION

In the last two decades, an international group of scholars – the Obsessive-Compulsive Cognitions Working Group (OCCWG) – trying to perfect a cognitive model of obsessive-compulsive disorder (OCD), has proposed and then further elaborated a set of 'belief domains' considered specific to OCD. In fact, the OCCWG originally identified six 'belief domains' that seem of central importance in OCD: 'exaggerated responsibility', 'over-importance of thoughts', 'thought control', 'over-estimation of threat', 'intolerance of uncertainty' and 'perfectionism' (OCCWG, 1997)[1]. Subsequently, however, the development of a questionnaire to evaluate these beliefs (Obsessive Beliefs Questionnaire - OBQ)[2,3] and the detection of a significant correlation between some of the subscales has led to a revision of the concept and to the identification of three empirically derived 'belief domains': 'responsibility/ threat estimation', 'perfectionism/certainty' and 'importance/control of thoughts' (OCCWG, 2005)[4].

From the specific point of view of the most accredited cognitive model of OCD so far[5-7], the importance of such 'belief domains' is quite evident. In fact, intrusive thoughts, images or impulses are considered ubiquitous phenomena that are widely present also in not-clinical population[8]. Then, the proponents of this model consider that these patients appraise their intrusions as meaningful precisely on the base of these specific dysfunctional beliefs[5-7]. For example, a person with OCD can evaluate the mental image of a misfortune as significant because he/she considers that the accident is possible, and even probable, precisely on the base of his/her

over-estimation of threat. In other cases, instead, a person with OCD may interpret the content of intrusions as significant because he/she considers it as revealing unacceptable, although hidden, aspects of his/her own self[9], a phenomenon now named 'fear of self'[10,11].

Consequently, mental intrusive phenomena would progressively become obsessive ones, because the subject tries unsuccessfully to drive them away, whereas a normal person does not feel the same need since he/she does not attribute any meaning and importance to them[6,7].

Of course, one can argue whether mental intrusive phenomena are always meaningless; in fact, at least in some cases, they seem instead very meaningful from an existential point of view[12]. One can think, for example, of the case of a girl who, before an important examination, every time she had the 'bad thought' of failing the exam, had to go back and replace the 'bad' thought with a 'good' one[13]. At the end, it seems quite understandable that a teenager, before an important examination, thinks about the possibility of failing it: of course, it really looks like an innocuous thought, but not like a meaningless one!

Moreover, the term 'belief domains' seems quite reductive, since these domains also take into consideration important emotional aspects: for example, 'exaggerated responsibility', 'intolerance for uncertainty' as well as the tendency towards 'perfectionism' do not seem to be merely intellectual phenomena. Moreover, in fact, the intense emotional states linked to the 'belief domains' do not seem only the product of explicit beliefs, but also the result of unconscious processes.

In short, the concept of 'belief domains' seems to present some problematic points. Nevertheless, even if one does not agree with all the points of the current cognitive model, there is no doubt that these domains are important aspects of OCD and among the phenomena that any psychopathological model of OCD must explain.

Recently, a new psychological process of interest for OCD, the Retrospective Identification of Motivations and Inclinations (RIMI), that seems to have a promising explanatory capacity for different aspects of OCD, has been proposed[14,15]. For example, it seems to make clearer [16] the concept of 'fear of self', that is the fear of OCD people of housing in their inner unacceptable aspects of Self[11,17]. However, the role of RIMI in OCD does not seem limited to the latter phenomenon, but it seems to play a role also in many other aspects of the disorder, as, e.g., the OCD related 'belief domains'.

Therefore, in the next paragraph RIMI will be briefly sum up, while in the following ones the possible role of RIMI in the different OCD related 'belief domains' will be discussed.

THE RIMI

The concept of RIMI has been developed recently[14,15], starting from of an analysis of subjective experience of patients with OCD and especially of its temporal course.

More precisely, the analysis consists of two phases: first, the choose of episodes of everyday life in which it is possible to identify a recognizable trigger of obsessive phenomena; secondly, the reconstruction, in the most precise way, of the exact sequence of mental events (images, emotions, thoughts, etc.) that, starting from the trigger, led to the obsessive phenomenon in question.

So, using this method it becomes evident that OCD people show a systematic tendency to retrospectively identify the motivations (or inclinations) of all their personal experiences (behaviors, mental images, emotions, thoughts or impulses) that they consider as unacceptable[14,15]. Such unacceptability can arise from different sources: objective negativity of the consequences of a given behavior, even if they were absolutely unpremeditated and not wished at all (i.e., hurting inadvertently someone); alleged infringement of some moral principle followed by the patient; perceived incompatibility between different emotions read as inconsistent or contradictory (although they are not contradictory at all).

Of course, the motivations (or the inclinations) identified in this way are inevitably only the alleged motivations (or inclinations) and not the real ones, that is to say those that effectively preceded the experience (behavior, thought, etc.) which so much upset the patient.

It is important underline that this retrospective process is not, at least in most cases, the result of an explicit reasoning, that is to say a true *a posteriori* deduction. Rather, RIMI is a process that occurs at a largely implicit level. This means that, although completely unaware of it, the subject shows a specific way of processing his/her experience, which consists in 'inferring' motivational states (in a tacit and retrospective way), instead directly recognizing them in direct connection[15].

If one wanted to translate this tacit processing into words, it is as if the patient were saying to himself/herself: «If I now have a behavior, a thought or an image X which I consider as unacceptable, this means that I already had inside me a latent tendency toward X»[15] (Figure 1).

It is important to underline that RIMI is recognizable both in the case of behaviors or mental events of everyday life and in the case of true intrusive mental phenomena. Indeed, it seems possible to say something more: that it is precisely a process as RIMI that helps to understand how ordinary mental phenomena can soon acquire an intrusive quality.

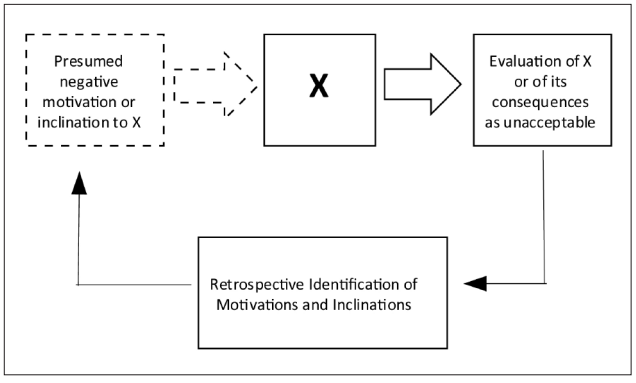

Figure 1. The diagram shows in broad terms how RIMI works. When a subject considers any X (behavior, thought, feeling, mental image, etc.) or its consequences as unacceptable, he/she will identify in a retrospective way the alleged motivation/inclination to X. Left box and left arrow are dotted because do not indicate a real motivation/inclination and real causal relationship but only presumed ones. *Modified from* Mannino[15].

In fact, it is easy to understand that, when an ordinary mental state is perceived by a subject (who is going to present an obsessive decompensation) as a clue of some malevolent intention upstream, every time it comes back to his/her mind it will be perceived as intrusive.

In the next paragraphs, RIMI will be used to try to outline a possible basis for OCD related 'belief domains'.

The role of RIMI in 'responsibility/threat estimation'

The concept of responsibility has always been considered an important aspect of OCD and all the attempts to outline an explicative model of OCD can not do without it. Indeed, responsibility in OCD shows several intriguing aspects.

First of all, as Rachman[18] has illustrated, the checkers, one of the two categories in which the obsessive subjects can be divided on the basis of their rituals[19], experience guilt or self-criticism, that can give rise to checking compulsions, only for the actions for which they could be held responsible.

In fact, when OCD people are in a place that they do not feel responsible for, they experience much less anxiety: in example, soon after hospitalization or going in holidays. Of course, with increasing time spent in new environment, the latter begins to be felt under own responsibility and rituals tend to remerge[13]. These observations allow us to reach a first fundamental conclusion: that OCD people, more than events in themselves, are afraid to feel responsible for them[18].

Moreover, OCD people often feel an intense sense of responsibility for (internal or external) events for which people without OCD do not feel responsible at all. For example, an OCD subject may feel guilty for something that comes to his/her mind (thought, mental image, etc.) that another person would not care about[5,10] (this topic will be addressed in the next paragraph). Sometimes OCD people experience an intolerable sense of responsibility even in ordinary existential situations. Anyway, in these cases too, RIMI seems to explain this increased sense of responsibility. A clinical case will be useful to explain this point:

Clinical case 1

A 22-year-old girl had been suffering from DOC for many years, especially in the form of doubts and ruminations. Her constant preoccupation – which often gave rise to exhausting ruminations – was that behind certain her choices there were some unworthy recondite motivations.

On one occasion, for example, she had come to the painful decision to close an affective relationship with a boy from whom she felt increasingly neglected. However, the mere possibility that he might somehow suffer from it made her feel like a 'Darwinist', that is, a person who discarded someone just because he no longer met her needs.

In this clinical case a sequence can be easily delineated, as shown in Figure 2.

Identifying in a clinical case the RIMI at work has important implications also for psychotherapy. For example, in this case the therapist has tried to reconstruct with the patient the state of mind that had led to her decision to close the relationship for how she had really felt it at the time, and not as she had identified it retrospectively. It clearly turned out that the patient, despite being reluctantly convinced of the need to close the relationship, was in fact worried about the pain she could have brought to the boy. This really made the decision particularly painful. The girl was very relieved to find out that her true feelings, in which she now recognized herself without problems, were completely different from the alleged ones.

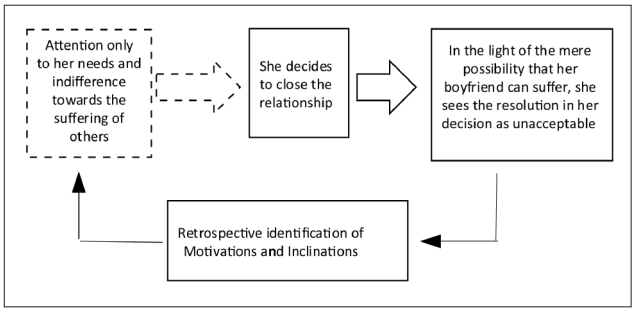

Figure 2. The diagram shows how RIMI works in clinical vignette 1. As in Figure 1, left box and left arrow are dotted because they do not indicate a true motivation and true connection respectively, but only the presumed ones. In this case, starting from the simple possibility that the boyfriend could suffer for her decision, the girl identifies in a retrospective way the presumed motivation for it.

Moreover, keeping in mind the concept of RIMI makes easier to understand also the phenomenon of the 'overestimation of threat'. Indeed, why do OCD people consider some feared events, although if remote, as possible and, in some cases, even probable? RIMI seems to provide a possible answer for at least some cases: because they think that danger's source is inner one. Thus, from the their point of view there is no exaggerated estimation of threat, but only a realistic one, since they think to know in a direct and unquestionable way that the danger is 'real'.

The role of RIMI in 'importance/control of thoughts'

An exaggerated importance attributed to thought has always been one of the most striking features of OCD. Strictly speaking, however, this phenomenon does not concern all the possible thoughts but only some. Indeed, as Straus[20] has pointed out in an expressive way, OCD people do not really consider themselves able to stop the movement of the sun only with the power of their thought. Rather, if a thought or an image with negative content comes to mind to an OCD person, often the latter does not even consider the possibility that it may be the result only of a spontaneous and involuntary process; instead, he/she immediately thinks that it is the product of some intentional process. How can this phenomenon be explained?

The process of RIMI provides a possible answer to this question: this happens because OCD people retrospectively identify their presumed motivations from thoughts or images that they consider unacceptable. Thus, since – in an OCD person's mind – the consequences of these thoughts are negative, the related motivations 'must' be negative too.

A clinical example can be useful to make this concept clearer.

Clinical case 2

A boy of 16, affected by OCD for some years, was very close to his older brother, who was about to go to university in another city. On one occasion the thought came to him that, when the brother had left, he would have had the room all to himself. He was very disturbed by this idea, because it seemed to him that it was incompatible with the affection he thought that everyone should feel for a brother and he read it as sign of a hidden desire to free oneself from his one. To contrast this (only presumed) bad motivation, he felt the urgent need to carry out some reparative behaviors that reassured him about his real good intentions.

As the sequence represented in Figure 3 outlines well, RIMI, first, seems to contribute to clear how mental phenomena, initially innocuous and even meaningful, may acquire an intrusive and ego-dystonic quality. Indeed, it is precisely through RIMI that OCD people identify presumed negative motivations, which should be upstream of the thought or mental image in question. At this point, the subject would not want to have this thought and try to drive it away; however, the attempt to no longer have thoughts on something that one continues to feel is evidently voted for failure. Consequently, whenever that thought reappears, the subject will experience it as intrusive and ego-dystonic.

Secondly, RIMI helps to explain, in broad terms, how compulsions give rise. Indeed, once the subject has recognized in himself/herself presumed negative inclinations he/she will comprehensibly feel the urgency to reassure himself/herself about existence instead of positive inclinations too. Hence the push for reparative behaviors that, over time, become ritualized.

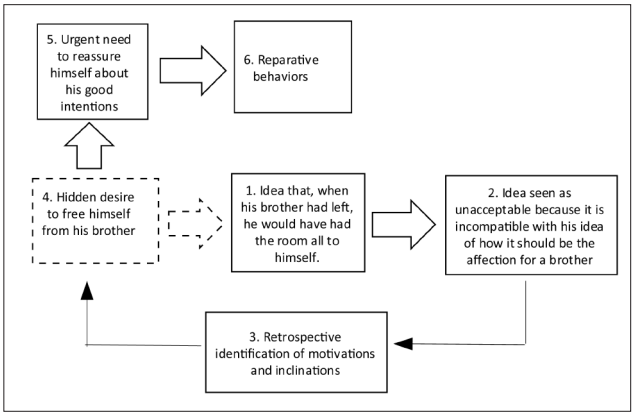

Figure 3. The diagram shows the role of RIMI in clinical vignette 2. To facilitate exposure the boxes were numbered. As in Figures 1-2, dotted box and arrow do not indicate a real motivation and a real connection respectively, but only the presumed ones. The sequence can be divided into the following steps: 1) the patient thinks of the advantage he could have at home once his brother is gone; 2) this idea seems unacceptable to him because it is incompatible with his vision of family affections; 3) through RIMI he identifies in a retrospective way the alleged motivation upstream of the thought; 4) these alleged motivation would be in his eyes the hidden desire to free himself from his brother; 5) soon he feels the urgent need to reassure himself about his real good intentions; 6) he performs behaviors to prove to himself that his intentions are good.

Of course, tightly related to over-importance of thought there is the equally important phenomenon of the need for control of thought: in fact, since the OCD people consider own thoughts or images as result of (alleged) negative motivations it is clear that they will become aware of the risk of not being able to keep them at bay. In other terms, since they consider their thoughts as possible clues to unacceptable motivations, they will feel the need to exercise a continuous control over thoughts themselves.

Moreover, RIMI seems to help understand, at least in part, that extreme kind of over-importance of thought called 'thought-action fusion' (TAF): that is, the belief that simply thinking about an action is equivalent to actually carrying out that action.

In fact, strictly speaking, this term refers to two partially different phenomena: 'moral' TAF and 'likelihood' TAF[21]. 'Moral TAF' has to do with the belief that thinking of an action is morally equivalent to putting it into action (i.e., thinking of lying is just seen as serious as actually lying). Instead, 'likelihood TAF' is implicated in the belief that simply having a thought about an event makes somehow that event more likely to occur (i.e., thinking that a disease affects someone increases the likelihood of this actually happening).

About this topic, it is interesting to note that RIMI seems first to help explain 'moral TAF'. Indeed, as highlighted above, what appears fundamental for OCD people is not whether an event happens or not, but whether they think they are responsible or not for it[18]. Therefore, if the person with OCD, through a process of RIMI, identifies a presumed negative intention behind his/her thought, in any case he/she will immediately feel guilty and a morally reprehensible person.

For what concerns the other kind of TAF, it includes at least two components: likelihood of events happening to others and likelihood of events that can happen to the subject himself/herself[22]. However, also other cases exist in which there is a sort of mixture of both previous kinds. For example, we can think of the following sequence of thought, taken freely from the work of Aardema, Moulding et al[23] (who however use sequences of this kind to illustrate a different concept): 'I think I'm a good mother… If I were a bad mother, I could even harm my son… My God, I just thought of harming my baby… So, I am a woman who would harm her child!'. Here, RIMI seems to explain well the process. Indeed, it is clear that this woman, starting from her thoughts, identifies – through RIMI – an (only alleged) negative inclination to harm her child. At this point, whether actually she is not guilty since she has not yet committed any crime, does not matter at all. Indeed, in her eyes the negative inclination that she thinks of hosting inside undoubtedly proves that she soon or later will become guilty also in deeds.

The role of RIMI in 'perfectionism/certainty'

Both 'perfectionism' and 'need for certainty' have always been considered key features of OCD.

As regards 'perfectionism', for the purposes of the present work one can resort to a simple and useful distinction between two forms of perfectionism: a positive and a negative

one. 'Positive' perfectionism can here be defined as the pursuit of reaching certain goals while 'negative' perfectionism, on the other hand, can be defined as the attempt to avoid mistakes.

From this point of view, perfectionism involved in OCD seems certainly to be a 'negative' one. In other terms, a perfectionism that aims to avoid mistakes unlike that recognizable in other conditions (i.e., Eating Disorders) that aims instead to achieve success in some goals important for the subject, as compliance with socially desirable standards (i.e., an attractive physical appearance)[24].

Besides, although perfectionism includes different aspects (i.e., concern over mistakes, personal standards, etc.), recent research has highlighted that one, which seems particularly related to overall OCD severity, is 'doubts about actions'[25]. This makes clear why perfectionism is closely linked to 'intolerance for uncertainty'.

At this point, the reader may ask some questions. For example, why is the perfectionism in OCD mainly a 'negative' one and why does it seem to consist mainly of 'doubts about actions'? RIMI seems to provide, at least in part, an answer to these questions.

Indeed, as illustrated above, OCD people tend to identify – in a retrospective way – presumed negative intentions from the negative consequences of their behavior. It does not matter if they are objectively negative or only subjectively evaluated as such; and it does not even matter that they are in any case unwished and completely unpredictable. Thus, it is clear that, if they consider any possible behavior as potentially dangerous, they will understandably become extremely prudent and conscientious and in need of certainty before acting. Moreover, it is equally clear why OCD people has mainly a 'negative' perfectionism, because instead of aiming at success, they tend to minimize the possible errors since it is from these that they retrospectively identify suspicious malicious intentions.

To illustrate the role of RIMI in all these phenomena here too a clinical example can be useful:

Clinical case 3

A young architect, who suffered from OCD for several years, on one occasion was undecided about how to conclude a project. At one point, he opted for a particular solution that seemed to him technically the most appropriate. However, a moment later, he thought with relief that this was also the fastest one that allowed him to return home first, after a long day at work. Immediately it seemed to him that satisfaction just felt was incompatible with his criteria of professional seriousness and then he retrospectively identified-upstream of it-a latent desire to avoid the necessary sacrifices required by a professional commitment. Soon he questioned the decision taken and fell into uncertainty again.

In the clinical vignette above it is easy to recognize the sequence shown in Figure 4.

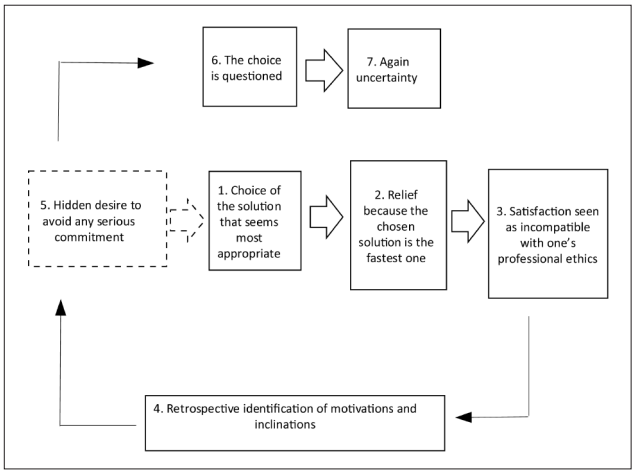

Figure 4. The diagram shows the role of RIMI in clinical vignette 3. To facilitate exposure the boxes were numbered. Dotted box and arrow, as the previous Figures 1-3, indicate only presumed motivation and connection respectively. The sequence can be divided into the following steps: 1) after a long reflection, the patient choices the solution that seems most appropriate to him; 2) at this point he feels a sense of relief because the chosen solution also seems to him the fastest one; 3) however, he soon perceives the feelings of relief and satisfaction as incompatible with his criteria of professional ethics; 4) through RIMI he identifies in an implicit and retrospective way the alleged inclinations and motivations upstream of the choice; 5) that would be the presumed hidden desire to avoid any serious professional commitment; 6) in light of this, the choice is questioned; 7) the patient falls again in uncertainty.

Hypothesis about the genesis of RIMI

How can one explain the origin of RIMI during the development? Here it is possible for now only to make hypotheses. Anyway, to try to find an answer to this question it seems necessary to take into account the parents' rearing style of a future OCD patient.

In this regard, at least three features of the caregiving style, as reported in literature, seem quite relevant. The first aspect consists of a pedagogical attitude, characterized by a clear predominance of verbal communication and of explaining over affective immediacy[26,27]. The second feature, instead, consists of a very demanding attitude, characterized by the expectation that the child shows a sense of responsibility that is absolutely disproportionate for the age[28]. Finally, the third aspect is represented by a characteristic emphasis on effort rather than on result[26].

These aspects are well known to clinicians[27,29,30] and some authors have even outlined the possible pathways from parental features (i.e. criticism) to one of the belief domains: the 'exaggerated responsibility'[30]. However, unfortunately there are still few empirical studies about these pathways[31-33].

In any case, Guidano[34] further illustrates this parents' attitude in a discursive way using an eloquent example. A little child, running around the house, breaks something. Normally a parent would simply scold the child and tell him to pay more attention in future; instead, the caregiver of a child, who once older will develop OCD, wants his son to think and to reason. Thus, he calls him and asks him insistently why he broke the object in question. Guidano[34] underlines that asking children questions that are too demanding for their logical skills is a kind of torture.

We can add here another point of particular importance for the purposes of understanding the genesis of RIMI. It is about this: that the particular insistence on explanations ends up encouraging the children to develop a tendency to identify at any cost, in an event that involves them and provokes their disapproval, some latent and secret intentionality even when the event is completely accidental[15].

SOME CONSIDERATIONS

So far, the psychopathological conceptualization of OCD seems to include different levels.

Indeed, precisely at the surface of the problem, we find a first level consisting in an accurate description and definition of the phenomena: the main clinical manifestations of OCD (i.e., obsessions and compulsions), the most frequent themes of obsessions (i.e., blasphemy, sexual, contamination, etc.), the main kinds of compulsions (i.e., checking, washing, etc.) and so on.

At an intermediate level, instead, we can find more elaborated constructs as the 'belief domains' described so far (exaggerated responsibility, over-importance of thoughts, etc.) that lie beyond the purely phenomenological level. These concepts are the result of an operation of abstraction performed by the observer: in fact, they are tacit assumptions often not spontaneously identified by the patients themselves.

Finally, at an even deeper level there can be concepts involving higher-order constructs as the construct of the Self. It is the case of the concept of 'self-ambivalence'[29], in whose light some authors have tried to reread also the belief domains[35].

If so, what place does RIMI occupy in this conceptual framework? A first answer is that RIMI is a construct belonging to a deeper level than that one 'belief domains' belong to. Indeed, as this paper tries to illustrate, RIMI seems able to shed new light on the 'belief domains' themselves as well as on some aspects of obsessions and compulsions. Moreover, since it appears to be a common denominator to all belief domains, RIMI may explain also the strong correlation between them.

At the same time, however, RIMI appears different from higher-order concepts belonging to a third level (as 'self-ambivalence'): not because it is in contradiction with those, but rather because it simply constitutes a more basic process. Therefore, it is possible that it belongs to a different and even deeper level. This should not be surprising. In fact, usually, a scientific explanation is considered such insofar as it succeeds in explaining the phenomena in question in terms of some basic fundamental elements. In hard sciences these elements, be they concrete (molecules, atoms or elementary particles) or abstract (mass, field, energy), are anyway basic concepts. Instead, of course, in so-called 'soft' sciences (as, i.e., psychology and, at least in part, psychiatry), where we have to do with complex living systems with emergent properties, these fundamental elements are very heterogeneous and can be even high-order constructs, which however may be for some time still vague and indefinite. In any case, as science progresses, these concepts would ideally have to become more precise and defined.

From this point of view, RIMI seems just to be an example of these more basic processes and it may not be ruled out that in the future it will be possible to explain the complex obsessive phenomenology on the basis of a limited number of processes of this kind, of which the obsessive beliefs could only be simple epiphenomena.

On the other hand, a limitation of the present work consists in the fact that it is essentially a theoretical paper. In fact, although starting from a careful psychopathological analysis of clinical cases, it does not yet presents experimental data able to support the proposed concepts. Anyway, since RIMI appears susceptible to experimental investigation, in the future also empirical research will be necessary to evaluate the validity of this concept as well as of its application to different aspect of OCD.

CONCLUSIONS

The psychological process discussed in this paper, although certainly not the only important one in OCD, looks to play a promising role for the purposes of a more clear and definite psychopathology of this disorder. This for several reasons.

In the first place, RIMI seems to shed new light on the 'belief domains' described so far in OCD. In fact, even if one does not agree completely about the role attributed to them within the current cognitive model of OCD, nevertheless they look like important aspects of the disorder that any model would have to explain.

Secondly, the concept of RIMI seems to be located at a level of explanation deeper than that of the belief domain's themselves and, for this reason, it looks capable to unify them and to let us understand why they show a so strong correlation. Besides, it is possible that RIMI lays at an even deeper level than that to which higher-order concepts such as 'self-ambivalence' belong. If so, it could be an example of those deeper and more basic processes that in the future could have a growing role in the further articulation of psychopathological models of OCD.

Thirdly, RIMI seems consistent with what we know about the parents' rearing style (as described in literature) of a person who will later develop OCD so that this contributes to give plausibility to the concept.

Of course, since this article is a theoretical paper, further research will be needed in future to evaluate RIMI also on an empirical ground.

Conflict of interests: the authors have no conflict of interests to declare.

REFERENCES

1. Obsessive Compulsive Cognitions Working Group. Cognitive assessment of obsessive-compulsive disorder. Behav Res Ther 1997; 35: 667-81.
2. Obsessive Compulsive Cognitions Working Group. Development and initial validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory. Behav Res Ther 2001; 39: 987-1006.
3. Obsessive Compulsive Cognitions Working Group. Psychometric validation of the Obsessive Beliefs Questionnaire and the In-

terpretation of Intrusions Inventory. Part 1. Behav Res Ther 2003; 41: 863-78.
4. Obsessive Compulsive Cognitions Working Group. Psychometric validation of the Obsessive Belief Questionnaire and Interpretation of Intrusions Inventory. Part 2: Factor analyses and testing of a brief version. Behav Res Ther 2005; 43: 1527-42.
5. Salkovskis PM. Obsessional-compulsive problems: a cognitive-behavioural analysis. Behav Res Ther 1985; 25: 571-83.
6. Salkovskis, PM. Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. Behav Res Ther 1989; 27: 677-82.
7. Rachman S. A cognitive theory of obsessions: elaborations. Behav Res Ther 1998; 36: 385-401.
8. Rachman S, de Silva P. Abnormal and normal obsessions. Behav Res Ther 1978; 16: 233-48.
9. Rachman S. A cognitive theory of obsessions. Behav Res Ther 1997; 35: 793-802.
10. Ferrier S, Brewin CR. Feared identity and obsessive-compulsive disorder. Behav Res Ther 2005; 43: 1363-74.
11. Melli G, Aardema F, Moulding R. Fear of Self and unacceptable thoughts in Obsessive-Compulsive Disorder. Clin Psychol Psychother 2016; 23: 226-35.
12. Mannino G. Psicopatologia esplicativa del disturbo ossessivo-compulsivo: una veduta post-razionalista. Riv Psichiatr 2011; 46: 343-8.
13. Tallis F. Obsessive Compulsive Disorder. A cognitive and neuropsychological perspective. Chichester, UK: Wiley, 1995.
14. Mannino G. Psicopatologia e psicoterapia del disturbo ossessivo-compulsivo: tra continuità e cambiamento. In: Reda MA, Canestri L (a cura di). Continuità, cambiamento, coerenza sistemica e complessità. Atti del XV Convegno di Psicologia e Psicopatologia Post-razionalista, Siena: Università di Siena, 2014.
15. Mannino G. Vecchi problemi, nuove soluzioni. Proposta di un nuovo meccanismo patogenetico per il Disturbo Ossessivo-Compulsivo. In: Puzella A, Serino M, Ranfone S (a cura di). La psicopatologia nel mondo che cambia. Roma: Associazione Crossing Dialogues, 2016.
16. Mannino G, Guerini R. A process that can throw light on the so-called 'fear of self' in obsessive-compulsive disorder: the Retrospective Identification of Motivations and Inclinations. Riv Psichiatr 2018; 53: 100-3.
17. Aardema F, Moulding R, Melli G, et al. The role of feared possible selves in obsessive-compulsive and related disorders: a comparative analysis of a core cognitive self-construct in clinical samples. Clin Psychol Psychother 2018; 25: e19-e29.
18. Rachman S. Obsessional-compulsive checking. Behaviour Res-Therapy 1976; 14: 269-77.
19. Rachman SJ, Hodgson R. Obessions and Compulsions. Englewood cliffs, NJ: Prentice Hall, 1980.
20. Straus EW. On Obsession: a clinical and methodological study. Nervous and Mental Disease Monographs 1948; 73: 1-92.
21. Shafran R, Thordarson DS, Rachman S. Thought action fusion in obsessive compulsive disorder. J Anx Disord 1996; 10: 379-91.
22. Amir N, Freshman M, Ramsey B, Neary E, Brigidi B Thought-action fusion in individuals with OCD symptoms. Behav Res Ther 2001; 39: 765-76.
23. Aardema F, Moulding R, Radomsky AS, Doron G, Allamby J, Souki EJ. Fear of self and obsessionality: development and validation of the Fear of Self Questionnaire. J Obsessive Compuls Relat Disord 2013; 2: 306-15.
24. Izydorczyk B, Sitnik-Warchulska K. Sociocultural appearance standards and risk factors for eating disorders in adolescents and women of various ages. Front Psychol 2018; 29: 429.
25. Martinelli M, Chasson GS, Wetterneck CT, Hart JM, Björgvinsson T. Percfectionism dymensions as predictor of symptom dimensions of obsessive-compulsive disorder. Bull Menninger Clin 2014; 78: 140-59.
26. Adams PL. Obsessive Children. New York: Brunner/Mazel, 1973.
27. Guidano VF. The Self in Process. Toward a post-rationalist cognitive therapy. New York: Guilford Press, 1991.
28. Salzman L. The Obsessive Personality. New York: Aronson, 1973.
29. Guidano VF, Liotti G. Cognitive processes and emotional disorders. New York: Guilford Press, 1983.
30. Salkovskis P, Shafran R, Rachman S, Freeston MH. Multiple pathways to inflated responsibility beliefs in obsessional problems: possible origins and implications for therapy and research. Behav ResTherapy 1999; 37: 1055-72.
31. Clark DA, Bolton D. Obsessive-compulsive adolescents and their parents: a psychometric study. J Child Psychol Psychiatry 1985; 26: 267-76.
32. Halvaiepour Z, Nosratabadi M. External. Criticism by parents and obsessive beliefs in adolescents: mediating role of beliefs associated with inflated responsibility. Glob J Health Sci 2015; 8: 125-33.
33. Collins LM, Coles ME. A Preliminary investigation of pathways to inflated responsibility beliefs in children with obsessive compulsive disorder. Behav Cogn Psychother 2018; 46: 374-9.
34. Guidano VF. El modelo cognitivo postracionalista. Hacia una reconceptualización teórica y crítica. Bilbao: Editorial Desclée de Brouwe, 2001.
35. Bhar SS, Kyrios M. An investigation of self-ambivalence in obsessive-compulsive disorder. Behav Res Ther 2007; 45: 1845-57.