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Core fears, values, and obsessive-compulsive disorder: A preliminary clinical-theoretical outlook

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Summary
In this paper, we describe the concepts of core fears and of values and propose that they play important interactive roles in the manifestation and treatment of obsessive-compulsive disorder using cognitive behavioral therapy. Core fears are defined as the ultimate feared consequence related to one’s obsessions that will occur if compulsions or other avoidance behaviors are not used. Values are defined by Schwartz (1992) as general beliefs related to prioritized life goals that guide choices or evaluation of behavior and events. We propose that obsessions and core fears are influenced by one’s values and that there are significant treatment implications to such a conceptualization.

Keywords: values, core fears, obsessive-compulsive disorder, treatment, theory.

Riassunto
Paure centrali, valori e disturbo ossessivo-compulsivo: un primo sguardo teorico-clinico
In questo lavoro verranno proposte descrizioni dei concetti di paure centrali e di valori, di cui saranno delineati i ruoli interattivi nella manifestazione del disturbo ossessivo-compulsivo e nel suo trattamento con la terapia cognitivo-comportamentale. Le paure centrali sono definite come le spaventose e terminali conseguenze relative alle ossessioni personali, che si realizzeranno se non saranno compiute le compulsioni o altre azioni di evitamento. I valori vengono definiti da Schwartz (1992) come credenze generali relative a scopi di vita prioritari che guidano le scelte o la valutazione di comportamenti o di eventi. Sarà suggerito che le ossessioni e le paure centrali sono influenzate dai valori personali e che da tale concettualizzazione derivino importanti implicazioni per il trattamento.

Parole chiave: valori, paure centrali, disturbo ossessivo-compulsivo, trattamento, teoria.

In this paper, we describe two concepts that we believe are often implied in theoretical models and cognitive-behavioral treatments (CBT) for obsessive-compulsive disorder (OCD), though they are typically not discussed. These two concepts are «core fears» and «values». First, we define each concept and place each within the framework of related
constructs and research. Then, we propose a relationship between core fears and values and describe how such a relationship may help clarify and hone idiographic conceptualizations for the treatment of OCD and other disorders.

**CORE FEARS**

When surveying experienced clinicians who treat OCD with cognitive-behavioral therapy (CBT), they readily acknowledge the importance of determining the ultimate or underlying fear that is related to the obsessions and compulsions. We call this the core fear.\(^1\) This is common practice during the initial stage of treatment planning in CBT for OCD, despite its neglect in the literature. Practically, this is done via a number of lines of questions that include the classic cognitive therapy downward arrow technique («What would happen if your hands became contaminated (the light was left on, etc.) and then what would happen? And then what? And then what?»; Beck, 1995; Leahy, 2003). It is also frequently initiated by asking what would happen if one stopped or was prevented from engaging in their rituals, followed by downward arrow questioning. While this hypothetical line of questioning is often useful, an in vivo experiment/exposure which activates the patient’s anxiety to a moderate level and then engages in the analysis is often helpful in soliciting an individual’s core fear when they are not able to articulate their fears just based on the hypothetical (c.f., hot cognitions; Beck, 1995). The goal of examining the core fear is to go beyond the patient’s fear of being anxious, distressed, uncomfortable, disgusted, or contaminated to the ultimate, core feared outcomes or consequences. At times, these consequences are the results of being in distress (I won’t be able to focus, relate to others, etc.), though often they are more direct results of not engaging in compulsions (dying, harming others, etc.; see Foa et al., 1995).

On a theoretical level, in cognitive behavioral therapy initial self-reported fears (evidenced in automatic thoughts and in obsessions) are often a reflection of deeper belief structures. While this notion is consistent with the principle of automatic thoughts and their relationship to core beliefs (Beck, 1976; 1995), we differentiate between core beliefs and core fears here. Core beliefs are typically viewed as one of two types of beliefs that comprise schemas (the other being conditional beliefs; see Padesky, 1994 for a review and description). Core beliefs are strong statements the individual makes about oneself, others, or the world. These are thought patterns that are consistently used to process the world and to determine how to act (Padesky, 1994). To differentiate core beliefs from core fears, core beliefs are more global, may relate to any type of emotion, and often describe a trait-like characteristic that the individual relates to oneself, others, or the world. In contrast, core fears are specific ultimate consequences which are anticipated to occur (implicitly or explicitly) either immediately or through a cascade of events if no action is taken to prevent it (i.e., avoidance or safety behaviors).

\(^1\) While we discuss core fear in the singular, we acknowledge that one may have more than one core fear. However, clinical experience suggests that oftentimes one can determine a primary fear that accounts for most of the patient’s obsessions most of the time.
Initial reports about a patient’s fears are often remote from their underlying fear (Borkovec, Ray and Stober, 1998). The notion that patients report surface fears and do not directly report and face their core fears can be viewed as a form of avoidance of more difficult content, similar to the way GAD patients are thought to use their worries to avoid more disturbing images or ideas (Borkovec, Alcaine and Behar, 2004). The concept of a core fear is similar to the fear structure discussed in emotional processing theory (Foa and Kozak, 1986; Foa, Huppert and Cahill, 2006). In emotional processing theory, the pathological fear such as the fear involved in OCD is comprised of a propositional network of associations of stimuli, responses, and meanings. The evocation of anxiety is therefore dependant both on the perceived existence of threatening stimuli or responses and on their interpretation as dangerous. Thus the closer a stimulus or response (thought, behavior, physical sensation) is to the core pathological fear, the more upset or distressed the individual will feel. Treatment requires the correction of the pathological associations amongst these elements.

Interestingly, there is little to nothing written about core fears in the OCD treatment literature and manuals, nor is it described fully in theoretical works. The main area wherein a similar concept has been explored is in a series of studies of fears in generalized anxiety disorder (GAD). In these studies, patients were interviewed using the downward arrow technique to examine the process of catastrophic worrying (Davey and Levy, 1998; Hazlett-Stevens and Craske, 2003; Vasey and Borkovec, 1992). In the most recent of these study, Hazlett-Stevens and Craske examined both the content areas and the process of worry and found that worriers found topics of interpersonal relationships, achievement, and economics as more threatening than non-worriers in an analog sample. These studies on GAD are based on Kendall and Ingram’s (1987) «What if» model of anxiety (c.f., Vasey and Borkovec, 1992). This «What if» model has been proposed to be one of the differentiating aspects of worry as compared to obsessions (Huppert and Sanderson, 2010): worry in generalized anxiety disorder tends to be more realistic and is characterized by «what if?» questions (e.g., «what if there was an accident?») while obsessions in OCD tend to be more unrealistic and often take an «If-then» form (e.g. «If I don’t cancel the thought that my child will be hurt in a car accident by imagining him safe at home, then he will be in a car accident»). The conditional built into the obsessional fear is the manifestation of the exaggerated responsibility characteristic of OCD (Salkovskis, 1985). Patients feel responsible to commit rituals in order to prevent their fears from coming true. We emphasize here that the evaluation of what they are ultimately trying to prevent by doing their rituals is an important component of treatment.

For a practical demonstration of core fears, we will consider a set of symptoms that are most common in OCD: contamination/washing. This same analysis could be done for most any constellation of OCD symptoms and perhaps for any other symptoms in general. First, let’s consider a patient with fears of contamination from money, doorknobs, and other objects that many other people have come into contact with. In our initial assessment, we will want to ask what will happen if she does touch these things. Oftentimes, the response is that it will lead the patient to compulsively wash. And if they don’t wash? They will feel bad, disgusted, and uncomfortable. For many clinicians, this sounds like a sufficient
answer, but we suggest that we need to continue. And what will happen if they continue to behave as if they had not touched the contaminated object? [this is to get around their avoidance]. Often, we can eventually get to consequences of a fear of getting ill from a disease such as AIDS (e.g., if I continue as if nothing happened, the germs will get in my mouth or enter my body and I will get AIDS). But is that truly the core of her fear? Why is she afraid of getting AIDS? What is the idiosyncratic meaning that getting AIDS holds for her? There are numerous possibilities: she may fear suffering and death, she may fear infecting her family members, maybe she fears social rejection as result of her sickness or maybe she is terrified of failure at work due to her becoming ill. Thus, we want to continue the downward spiral to determine the idiosyncratic core fear related to the person’s obsessions and compulsions. It is our clinical impression that diverse types of OCD symptoms often emanate from the same underlying core fears in the same individual. And that these underlying core fears are related to the individual’s values. Thus, if asked why the patient has these particular core fears, we would suggest that if she is afraid of contaminating her family, that her fears are related to how much she cares for her family and her values of security and protecting them. If she is afraid of failure at work due to illness, then it is related to her value of achievement. In sum, we suggest that OCD attaches itself to whatever is most important to the patient, their values.

VALUES

Each person has a set of values, an idiosyncratic set of ideals he wants to achieve (Schwartz, 1992). Schwartz and Bilsky (1987; 1990) following in the steps of Rokeach (1973), defined values as (a) concepts or beliefs, that (b) pertain to desirable end states or behaviors, (c) transcend specific situations, (d) guide selection or evaluation of behavior and events, and (e) are ordered by relative importance. Schwartz (1992) developed a set of ten motivationally distinct values that are relatively comprehensive in that they encompass virtually all the types of values to which individuals attribute at least moderate importance as criteria of evaluation. These values were theoretically derived from basic human needs such as survival and cooperation, and then validated in cross-cultural research (e.g. Schwartz, 1999; 2004). Studies all around the world reveal systematic associations of many behavior, attitude, and personality variables with these values (see citations in Bardi and Schwartz, 2003; Schwartz and Bardi, 2001). Table 1 lists these 10 value types. Each value is defined in terms of its central goal (that is, the desired end-state to which it is directed). The theory not only defines the basic motivational values, it also proposes a description of the relations between them. Some values oppose each other (such as self direction and conformity) while other values are highly correlated (such as achievement and power). These relations form a circular structure as illustrated in figure 1, so that the closer two values are on the circle the more they agree and the further they are positioned the more they are antagonistic to each other. Beyond presenting a comprehensive theory of values researchers have developed several well validated measures of values such as the Rokeach Value Survey, the Schwartz Value Inventory and the Portrait Value Questionnaire (Rokeach, 1973; Schwartz, 1999; 2007; Schwartz, 1992).
We argue that core fears are intimately associated with values. To do this we will first present theoretical arguments that connect values and core fears, then we will explore the phenomenology of values in OCD.

In his description of the idiosyncrasy of emotions Beck (1976) coined the term personal domain to describe the way a person attaches meaning to events or objects around him, thus widening his perception of himself. Core fears fit this description in that they identify the true meaning a person attaches to a specific fear. The realization that fears are deeply connected to the personal domain or to elements of the self leads us to seek the origins of core fears in the world of values. Values are central elements of the self that are also related to the meaning people give to things around them, but how would they be related to core fears? We propose that a person’s core fears will be connected to the frustration of these ideals. For example a person that has «personal achievement» as a value is likely to have «being a failure» as his core fear, regardless of the form his OCD symptoms may take.

The theoretical link we draw between fears and values is based on the understanding that both core fears and values have to do with the desired states of objects. On the basis
of the 5 criteria defining values above, it seems clear why core OCD fears could be defined by values: core fears are likely to be the fear of not achieving one’s most important desired end states unless certain behaviors (or thoughts) are engaged in (i.e., rituals). As Schwartz, Sagiv and Boehnke (2000) state, if values define the desired states a person pursues, and fears entail perceived danger of discrepancies from these desired states, then a person’s fears should be a function of his or her values. While this was written about worry, we believe the same should hold true for obsessional fears. For example the most important end state for a «benevolent» person may be the welfare of his family. A corresponding core fear may be that if he does not check the locks on the door his family may be hurt.

Schwartz, Sagiv and Boehnke (2000) used this understanding to study the relation between worries and values. They defined worry as «An emotionally disturbing cognition that a state of an object... will become discrepant from its desired state». We define obsessions in a way similar to Schwartz, Sagiv and Boehnke (2000): «an obsession is a disturbing cognition that if one doesn’t [perform a ritual] then an object will become discrepant from...»

Table 1 – Definitions of the motivational types of values and the single values used to index them in this study (Schwartz, 1992)

<table>
<thead>
<tr>
<th><strong>POW</strong></th>
<th>Social status and prestige, control or dominance over people and resources (authority, social power, wealth, preserving my public image)</th>
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<tr>
<td><strong>ACHIEVEMENT</strong></td>
<td>Personal success through demonstrating competence according to social standards (ambitious, successful, capable, influential)</td>
</tr>
<tr>
<td><strong>HEDONISM</strong></td>
<td>Pleasure or sensuous gratification for oneself (pleasure, enjoying life, self-indulgent)</td>
</tr>
<tr>
<td><strong>STIMULATION</strong></td>
<td>Excitement, novelty, and challenge in life (daring, a varied life, an exciting life)</td>
</tr>
<tr>
<td><strong>SELF-DIRECTION</strong></td>
<td>Independent thought and action-choosing, creating, exploring (creativity, freedom, independent, choosing own goals, curious)</td>
</tr>
<tr>
<td><strong>UNIVERSALISM</strong></td>
<td>Understanding, appreciation, tolerance, and protection for the welfare of all people and for nature (equality, social justice, wisdom, broad-minded, protecting the environment, unity with nature, a world of beauty)</td>
</tr>
<tr>
<td><strong>BENEVOLENCE</strong></td>
<td>Preservation and enhancement of the welfare of people with whom one is in frequent personal contact (helpful, honest, forgiving, loyal, responsible)</td>
</tr>
<tr>
<td><strong>TRADITION</strong></td>
<td>Respect, commitment, and acceptance of the customs and ideas that traditional culture or religion provide (devout, respect for tradition, humble, moderate)</td>
</tr>
<tr>
<td><strong>CONFORMITY</strong></td>
<td>Restraint of actions, inclinations, and impulses likely to upset or harm others and violate social expectations or norms (self discipline, politeness, honoring parents and elders, obedience)</td>
</tr>
</tbody>
</table>
its desired state». Schwartz, Sagiv and Boehnke (2000) showed that there is a clear correlation between worries and values. What we propose is that the same form of relation exists between obsessions and values. Perhaps the closest work to date that suggests this may be correct is the line of research that has found that more distressing obsessions tended to be more meaningful or related to valued aspects of the self than less distressing obsessions (Rowa and Purdon, 2003; Rowa, Purdon, Summerfeldt and Antony, 2005).

**MORALITY, VALUES, AND OCD**

When one hears the concept of values, it is likely to trigger an association with morality. However, morality is the principle concerning the distinction between right and wrong (Oxford English Dictionary online, September 6, 2011), while values are standards of one’s behavior, of what is important in life. The idea that moral preoccupation is related to OCD has been a part of the psychiatric literature since the beginning of the 20th century. For example, Freud (1909) suggested that persistent unwanted aggressive, horrific, or sexual thoughts accompanied by ritualistic behaviors are the result of unsuccessful defense mechanisms against potential violations of moral standards. More recently cognitive theories of OCD have also implicated morality issues in OCD, for instance Rachman and Hodgson (1980) note that individuals with OCD are of «tender conscience», and Salkovskis (1989) suggested that individuals would be sensitive to intrusions that infringe upon their moral beliefs. Indeed, there is a growing body of research looking at morality and its relationship to contamination and other OCD-related behaviors (Doron, Moulding, Kyrios and Nedeljkovic, 2008; Zhong and Liljenquist, 2006). Additionally, some have found associations with religiosity and OCD symptoms while others have not (see Greenberg and Huppert, 2010). To summarize, the distinction among religiosity, morals, and values are that the former two are a specific prioritizing of values. We suggest that while this specific prioritizing may influence the nature or manifestation of OCD symptoms, that morality is neither necessary nor sufficient for determining the range and scope of OCD symptoms, while values may be able to explain more of the variance.

Despite the recurring theme of morality in OCD theory it seems that there is very little evidence of a causal relationship between morality and obsessive compulsive pathology. Though values vary widely across cultures (e.g. Fontaine, Poortinga, Delbeke and Schwartz, 2008; Schwartz, 1999), epidemiological studies examining multiple, diverse cultures, suggest that lifetime and annual prevalence rates of OCD do not differ by culture except where prevalence rates for all psychiatric disorders differ (e.g. Horwath and Weissman, 2000; Weissman, Bland, Canino, Greenwald et al., 1994).

**WHAT IS THE RELATIONSHIP BETWEEN VALUES AND OCD?**

Assuming there is a connection between core fears and values, we should next ask what form does the connection take within OCD?

Examining the connection between cultural values and OCD, scrupulosity comes to particular notice. Scrupulosity is a form of OCD in which religious symptoms are
dominant (Greenberg and Huppert, 2010), and is naturally characterized by being highly dependent on the culture of the subject. Studies examining the connection between religiosity and OCD fail to find any association between religiosity and the development of clinical symptoms of OCD (see Greenberg and Huppert, 2010 for a review). In contrast, Greenberg and Shefler (2002) have found that Ultra-orthodox Jews are far more likely to have religious symptoms than non-religious symptoms. These facts suggest that culture and the values associated with it may have significant impact on the form OCD takes, rather than its intensity or presence. These findings lead us to theorize that similarly, values whether personal or associated with a particular religion or a given culture do not cause OCD but influence its particular form. Thus a person who values benevolence will not be particularly prone to OCD but if he has OCD, we’d expect his core fears to be related to his benevolence. Empirical study, however, is needed to examine the relationship between values and OCD and if and how the type of core fear affects the symptomatology of OCD.

One possibility is that particular forms of psychopathology gravitate towards particular values, for instance, social anxiety may load on achievement (Moscovitch, 2009) and it seems reasonable that OCD will load on the values ranging from benevolence through security. Furthermore if we look into sub-domains of OCD ( Foa et al., 2002; Mataix-Cols, de Rosario-Campos and Leckman, 2005) it seems reasonable that washing is related to security, checking/doubting to tradition and conformity, obsessing (aggressive, sexual, and religious themes) to tradition and benevolence, and ordering to conformity. This possibility assumes that core fears are tightly connected to the symptomatology of OCD.

A different, more radical, possibility is that there is absolutely no relation between the core fears and the symptomatology of OCD. Values are then proposed to influence the content of the core fears but not be directly related to the symptomatology. For example, returning the contamination fears stated above, someone who has a fear of contamination and washes compulsively could be concerned ultimately with almost any value (power, hedonism, benevolence, security, etc.).

Ultimately, we propose that values account for some of the variance in OCD symptoms and more of the variance in core fears. This, of course, needs extensive empirical study. Such a relationship has both theoretical (described above) and clinical implications, which we describe next.

CLINICAL IMPLICATIONS

We believe that there are a number of clinical implications of this suggestion:
1. Core fears have a profound influence on patients’ lives. Many patients ask where do my fears come from? Why do they take the form they do? Where do my obsessions or compulsions come from? The understanding that core fears and obsessions may derive from one’s values may allow therapists to normalize fears and calm patients.
2. Patients may feel understood and therefore more motivated when they understand their core fears and the connection between their personal values and their symptoms and core fears.
3. Using this conceptualization puts the therapist on the side of patient in supporting his/her values.

4. Having a clear understanding of core fears may also allow therapists to articulate core fears more clearly and easily when working with patients. Access to the core fears can directly affect the effectiveness of the treatment both in cognitive and exposure work.

5. Exposures can be more effective if core fears are articulated while executing exposures during exposure and response prevention. Specific outcomes can be tested more clearly, and exposures can be designed more particularly to the individual’s core fears, including having the patient articulate what specific risks they are taking when engaging in the exposure. When patients understand what they are challenging and that doing so is actually consistent with their values, they are likely to show greater willingness to engage in difficult exposures, and to accept their thoughts by allowing the patient to say things such as: «I will hold the knife when I am around my son and take the risk I will harm him because I want to gain control of my life and do the things that make me a good parent».

6. Identification and articulation of core values helps motivate ritual prevention by helping the patient to say things such as: «In order to be good father, I will do positive things with my child and will not engage in behaviors that have previously taken away from this (safety behaviors and rituals)». 
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