

To be published in: Anxiety Disorders – editors: David S. Baldwin & Brian E. Leonard

Sanneke de Haan & Erik Rietveld & Damiaan Denys

Final version – No.2 (17.07.2012)

Title: On the nature of obsessions and compulsions

Authors:

Sanneke de Haan (1), Erik Rietveld (1,2), Damiaan Denys (1,3)

Institute:

(1) Department of Psychiatry, Academic Medical Center, University of Amsterdam,

(2) Department of Philosophy, University of Amsterdam

(3) The Netherlands Institute for Neuroscience, an institute of the Royal Netherlands Academy of Arts and Sciences, Amsterdam, The Netherlands

Short title:

Nature of obsessions & compulsions

Full address of corresponding author:

AMC Psychiatrie

Sanneke de Haan

Postbus 22660

1100 DD Amsterdam

The Netherlands

Phone: +31 (0)208913600

Fax: +31 (0)208913701

Email address: Sanneke.deHaan@amc.uva.nl

Abstract:

In this chapter we give an overview of current and historical conceptions of the nature of obsessions and compulsions. We discuss some open questions pertaining to the primacy of the affective, volitional or affective nature of obsessive-compulsive disorder (OCD). Furthermore, we add some phenomenological suggestions of our own. In particular, we point to the patients' need for absolute certainty and the lack of trust underlying this need. Building on insights from Wittgenstein, we argue that the kind of certainty the patients strive for is unattainable in principle via the acquisition of factual knowledge. Moreover, we suggest that the patients' attempts to attain certainty are counter-productive as their excessive conscious control in fact undermines the trust they need.

On the nature of obsessions and compulsions

To be published in: Anxiety Disorders – editors: David S. Baldwin & Brian E. Leonard

Sanneke de Haan & Erik Rietveld & Damiaan Denys

Final version – No.2 (17.07.2012)

I. Introduction

Obsessions and compulsions are easily comprehensible and utterly elusive. They are comprehensible because we are all familiar with their mild variants. When we go on vacation, we double check whether we locked the door – just to be sure. Of course we know it is nonsense, but still, we knock on wood when we talk about our hopes. After all, it won't do any harm either. We may have superstitious rituals, lucky numbers, unlucky numbers and the like, and even be a little upset when we cannot indulge these preferences. In this sense we can understand the urge to do something that we recognize as not being entirely reasonable. Likewise, we may also be familiar with annoying thoughts or images that keep on popping up. In fact, it is our everyday experience that thoughts and images pop up rather than that we deliberately develop them. This lack of control is usually no problem – until it is our explicit intention *not* to think of something. Wegner and colleagues [1] described the now classical experiment in which they instructed participants NOT to think of a white bear. Paradoxically, this and other experiments [2] show that the attempts to suppress a specific thought or image in fact leads to its more persistent re-appearance. So the uncontrollability of our thoughts and imagination and the concomitant adverse effects, which appear if one does try to keep them under control, is not alien to us either.

However, when obsessions and compulsions get out of hand, when people devote their whole day endlessly moving chairs so that they form a perfectly straight line with the table, or cement them to avoid changes, this seems to be something completely different. Patients with obsessive-compulsive disorder (OCD) may wash their hands until they bleed, may not leave their houses for fear of contamination, or may check on the oven or windows for hours on end. It is not that they *want* to do these things: they regard their compulsive behaviour as pointless – or at least as completely disproportional. They feel compelled to do so, since *not* doing these things brings forth an extreme experience of tension and anxiety. They agree that it is nonsense and that their compulsive activities are not helping them, and this actually makes their condition all the more elusive. For instance, when we compare their behaviour to that of schizophrenic patients, the latter may act in strange ways, but at least that is in line with their delusions: their behaviour is coherent with their thoughts. People suffering from OCD are rather 'split' in that they do things they do not want to do. Understandably, this increases their suffering, their feeling of being unfree, and the shame for their behaviour, in particular since they are otherwise cognitively completely healthy.

In this chapter we will explore the nature of obsessions and compulsions. We start by looking at the criteria for OCD as laid down in the DSM IV. We will then give a historical overview over the general development of thinking about what we now call OCD. In the last

sections, we will point to some open questions, and add some of our own interpretations.

II. DSM Criteria

According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), obsessions are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress [3]. Moreover, the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action. Also, the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (thus not imposed from without as in schizophrenic thought insertion) [3].

In an attempt to cope with the anxiety and distress that are caused by the obsessions, people start to develop repetitive acts or specific rituals. *Compulsions* are defined as repetitive behaviours or mental acts (e.g. praying, counting, repeating words silently) that the person feels driven to perform. These mental acts and behaviours are either aimed at preventing or reducing distress or at preventing some dreaded event or situation, but they are either not connected in a realistic way with what they are designed to prevent or they are clearly excessive [3].

Moreover, the diagnosis of OCD requires that, at some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.¹ The obsessions and compulsions must also induce some impairment: they cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational functioning, or social activities or relationships [3].

The insight in the unreasonableness of their behaviour is an important characteristic to set OCD apart from both delusions and obsessive-compulsive personality disorder (OCPD). The outward behaviour may be very similar, and accordingly it may require careful phenomenological analysis of the person's experiences to arrive at an adequate diagnosis [4]. Bürgy [5] describes an exemplary case in which OCD and paranoid delusion could easily be confused. The patient concerned suffers from repetitive hand washing and endless dressing rituals: two common forms of compulsions for OCD patients. The patient moreover explains that he acts this way because 'he is not sure whether he had done it properly' [5] (p. 294) – again a worry that many OCD patients also voice. However, further exploration revealed that this patient actually had the suspicion that it was someone else who was performing these actions. What had lead him to these endless repetitions was the uncertainty whether they 'were still his own hands and movements' [5] (p. 295).

The distinction between OCD and OCPD may be complicated as well. In OCD, patients experience their compulsions as not belonging to them, that is, as '*ego-dystonic*'. In OCPD patients there is no such split or estrangement: their compulsive behaviour is rather part of how they see themselves, or '*ego-syntonic*'. Typically, OCPD patients do not see their own behaviour as problematic: being perfectionistic themselves, they rather have problems with lack of orderliness

¹ This does not apply to children.

of their loved ones. For most patients it will be clear whether or not their compulsions seem alien to them. But there are also patients who have a more ambiguous relation to their need to clean, order, or control things. They would for instance admit that their behaviour is excessive, but at the same time stress that it is also important to be tidy and meticulous. Accordingly, in these patients, the distinction between OCD and OCPD will be harder to make.

As Denys [6] points out, we can distinguish three main conceptualisations of OCD depending on which faculty is taken as central: affective (anxiety), volitional (compulsive), or cognitive (obsessional). At present, OCD is classified as an anxiety disorder. This is reasonable, given the driving force of tension and anxiety that most patients experience. However, not all patients report anxious feelings [7-8]. Some argue that OCD is more akin to disorders of impulse control such as addictions – which puts the volitional component at center stage [9]. Others point to the cognitive disturbances of OCD patients, in particular their lack of cognitive flexibility [10].

Currently, a new edition of the DSM is being prepared. On the official website of the American Psychiatric Association, one can find the proposed revisions [11]. It is proposed that OCD is no longer subsumed under Anxiety Disorders, but that a separate chapter of ‘Obsessive-compulsive and related disorders’ is formed which brings OCD and all OC-spectrum disorders under one heading. With regard to the definition of OCD, the proposal acknowledges that obsessions usually, but not always cause marked anxiety or distress. The main difference is the proposed amendment of a differentiation in the level of insight – good or fair, poor, or absent. In the case of absent insight, the question is whether such delusional beliefs should not be categorized as a psychotic disorder rather than OCD, as the current definition implies. In 2010, the DSM-V workgroup ‘Anxiety, Obsessive-Compulsive Spectrum, Post-traumatic, and Dissociative Disorders’ [8] recommended the elimination of ‘OCD’s delusional variant’ (p.513) from the psychosis section, but this question is not yet resolved [11].

III. Historical overview

In hindsight we can distinguish obsessions and compulsions in various historical cases, most of which are of a religious nature (probably also because clerics were the writing class and thus these cases are more likely to be reported, as Berrios [12] rightly remarks). However, even though the development of psychiatry as a medical discipline had been taking shape for some decades, it was not until 1838 that the first case description of what we would now call OCD was published by the French psychiatrist Esquirol. Thirty years later, in 1868, the German psychiatrist Griesinger still speaks of ‘a little known psychopathical condition’ [13] when he describes three patients suffering from obsessions and compulsions. Their condition may be so unknown, because these patients cannot be found in a mental asylum, but still move around freely, as Griesinger remarks.

A growing recognition of obsessions and compulsions lead to varying conceptualisations and definitions during the 19th century, mostly by French and German psychopathologists. Drawing on case studies, they tried to understand nature of the problems of their patients and to carve out a common structure that would justify grouping these problems together as different instances of the same disorder. At the same time, they were concerned with classification: they

wanted to find out not only whether these problems could be united as one disorder, but also how this disorder could be distinguished from other psychiatric conditions. As noted earlier, OCD may be conceptualised according to its affective, cognitive and volitional nature, and so can its historical development. We can distinguish those who regarded *emotions* (especially anxiety) as central, those who regarded the problems as stemming from a lack of *will power*, and those who considered the *intellect* to be at the root of the problems.

Early developments

In 1838, Esquirol [14] wrote about one of his patients, ‘Mademoiselle F’, and therewith provided the first description of a classical case of what we now call OCD. He described her fear that she might steal what she touched and how she tried to keep her thoughts under control by washing her hands or standing on one leg for hours. Her behaviour appears to be ‘involuntary, irresistible and instinctive’. She consciously rejects these actions, but her will does not succeed in trying to resist. Esquirol points out that her rejection of these activities signals that she has some insight. He therefore characterized her condition as a ‘*délire partiel*’, a partial madness. According to Esquirol, these problems were neither due to reason nor emotion, but rather reflected a *weakness of the will*. He concluded that Mademoiselle F. suffered from a form of volitional ‘*monomanie*’.

In 1866, Jules Falret [12] introduces the term ‘*maladie du doute*’ (also called ‘*folie du doute*’), pointing to the pathological doubt involved. In that same year, Morel’s analysis of seven patients was published. Like Esquirol, Morel [15] also regarded the insight of the patients into the foolishness of their actions to be a major characteristic of their condition. He however disagreed with Esquirol’s analysis of the problem: Morel thought their condition was rather a ‘disease of the emotions’ [12] – with anxious doubt being the central emotion. This ‘*délire émotif*’ would stem from disturbances of the central nervous system. For Morel, the patients’ insight implied that they do not suffer from a ‘true’ madness. He studied the disorder quite extensively and listed some predisposing factors for its development: (1) suffering or a great loss; (2) stopping with an active life; (3) long-lasting insomnia; (4) excessive intellectual efforts; (5) heredity [16].

A year later, Von Krafft-Ebing [17] introduces the word ‘compulsion’ (*Zwangsvorstellung*). He generally agrees with Morel’s perspective: he too thinks the central nervous system plays a crucial role. He also agrees with Morel that a traumatic experience can trigger the disorder – although some patients develop these symptoms ‘out of the blue’: in those cases it must be a genetic disposition that is at work.

It is important to realize that both Morel and Von Krafft-Ebing did not draw the boundaries of the disorder in the way that we do now. As Berrios [12] points out, Morel’s category of ‘*délire émotif*’ was very broad and included also ‘vasomotor and digestive symptomatology, phobias, dysphoria, unmotivated fears, fixed ideas, and compulsions’ (p.285). His main criterion was the lack of cognitive impairment. Von Krafft-Ebing too was not referring to our present-day definition of OCD when he introduced the word ‘compulsion’: he used it to describe a phenomenon concerning the structure of the course of thinking. In fact, he used ‘*Zwangsvorstellung*’ as it occurred in a patient suffering from melancholic mood to describe the compelling force with which certain mental acts result in other mental acts, such as melancholic thoughts following melancholic mood.

Westphal

It is Westphal's [18] definition from 1878 which stands at the basis of our present definition of OCD. He writes:

'By obsessive images I understand those which, with intelligence being otherwise intact and without being conditioned by an emotional or affect-like state, step into the foreground of consciousness against the will of the person concerned and cannot be chased away and which hinder or interfere with the normal course of images, which the person affected continually acknowledges as abnormal and alien to him and which he faces with his sane consciousness.' (p.734).

Like his predecessors, he sees the patients' insight in their condition as a crucial and distinguishing feature. And like Griesinger, he relates this insight to the patients' experience of shame and their efforts to hide their problems for others. His analysis of the disorder, however, differs. Contrary to Morel and Von Krafft-Ebing, Westphal regards the anxiety of the patients as a secondary effect of the obsessive thoughts. The disorder does not have an emotional basis: it is rather a disorder of the *course of thinking*. It is the occurrence of obsessive thoughts that subsequently frightens the patients. Accordingly, he does not think that emotional experiences can trigger the disorder.

Similarly, Westphal considers the weakness of the will a secondary phenomenon too. The obsessions can acquire such intensity that, for the time being, they force back all healthy thoughts and images, and thus direct the will accordingly: either by acting in a particular manner, or by avoiding specific actions. He acknowledges that patients themselves think it is their weakness of the will that is their problem, but when they say that, they mean the same thing, he says, namely that their healthy thoughts are too weak to fight the impulses that accompany the obsessive images ([18] Footnote 4). In the battle between the will and the obsessions, the obsessions win. Because the obsessions are too strong, says Westphal. Because the will is too weak, says Esquirol.

Westphal has also been influential by introducing the sequence of the primacy of the obsessions, which subsequently may lead the patient to perform (or avoid) certain activities. He also distinguished a third, very severe stage of the illness, namely those patients for whom a 'direct connection' between obsession and impulses of the will (hence activities) takes place. However he regards this third category as very rare and in his text does not further explain this condition. As we saw, the DSM IV has adopted only the two-stage view, but applies it less flexibly than Westphal did, largely influenced by the paradigmatic anxiety conditioning theory of behaviour therapists. Besides, Westphal approached OCD in terms of the development of the disorder, which was a popular approach at that time, whereas the DSM IV gives a more static definition, neglecting the evolution of symptoms.

Janet & Von Gebsattel

At the turn of the twentieth century, with the rise of phenomenological psychiatry, some interesting phenomenological analyses of obsessions and compulsions have been put forward. We restrict ourselves here to the descriptions provided by Janet and Von Gebsattel. Like Westphal, Janet [19] also argues for three stages of illness: psychasthenic state, forced agitations,

and obsessions and compulsions. And Janet too regards anxiety as a secondary phenomenon. In his opinion, the most basic factor in the illness is that patients feel that 'actions they perform are incompletely achieved, or that they do not produce the sought-for satisfaction' [20] (p.226). They are 'continually tormented by an inner sense of imperfection' [20] (p.226). This sense of incompleteness often pertains to their perceptions also, leading to doubts, and even derealisation. In this way, Janet's account suggests that this feeling of incompleteness is at the root of the insatiable doubts.

Several decades later, the German psychiatrist and philosopher Von Gebsattel [21] took a more phenomenological approach to the disorder, which means that he tried to understand the disorder by investigating the way in which the patient relates to the world, to people, and to herself. Von Gebsattel characterizes the relation between obsessive and compulsive patients to their world as one of 'fearful disgust' (*phobischer Ekel*). This disgust not only pertains to things having to do with death and decay (all that is 'aversive to life' and that we cannot possibly sympathize with), but is also related to dirt in the metaphorical, moral sense of that which is sinful. The world of people suffering from obsessions and compulsions is one filled with dangerous or repulsive objects and possibilities for action. We may all know how the physiognomy of the world may suddenly change, Von Gebsattel writes, for instance when we are drawn to a friendly meadow to rest there and all of a sudden a poisonous snake sizzles up. We are then confronted with the threatening side of the environment where we felt so at ease in only a minute ago. This is what the world of obsessive-compulsive patients looks like all the time: they constantly perceive lurking dangers, reasons to worry, and potentially harmful events. Consequently, they feel unsafe in their world. As Von Gebsattel remarks: 'their world lacks the peaceful foundation' (p.99) that we are used to rely upon. We take things for granted in normal life and unthinkingly assume harmless scenarios, while in OCD the patient does not.

Patients continuously try to dispel the chaos and potential destruction through their overly ordered, repetitive rituals. Their activities are not actions in the strict sense of the word because they are aimless, they serve no purpose. There is no progression, no future directedness, only a repetition of a series of instances of 'now'. Commenting on Von Gebsattel, Glas [22] points out that this obstruction of time leading anywhere can be seen as an ultimate attempt to stop the perpetual decay and destruction that comes with the passing of time. With these endless and sterile activities, patients try to control their worlds, to keep the destructive chaos at bay.

We can add here a distinction that Arendt [23] makes between labour, work, and action. Labour refers to activities that are aimed purely at staying alive and keeping our world liveable, like cooking and cleaning. These are the necessary everyday routines that we need to perform over and over again because otherwise decay (of food) or chaos (of our home) would follow. It forms the precondition for the other forms of activity. When we work, we aim to produce something longer lasting, like tools, or clothing. Here the time-scale is one of decades rather than days. Lastly, we humans are capable of actions. For Arendt, actions refer to our political and societal deeds: our participation in a community. It is through our public engagement that we can actualize our human freedom. Although labour is necessary for survival, and work is necessary for shaping our worlds, it is our capacity for acting that characterizes us as humans. Undertaking actions, engaging oneself in a community is however also the least controllable of all activities. We can never predict exactly how our actions will turn out, because this will depend on the other

citizens in our community. To prevent that this unexpectedness leads to chaos, we have the possibility to make promises on the one hand, and to forgive on the other hand [23].

When we consider the activities that OCD patients perform, they are all in the realm of labour: cleaning the house, ordering, and washing oneself. For Arendt labour serves the continuous securing of our environment. Indeed, cleaning your house is reconquering your home, re-establishing your home as yours. The compulsions appear to be an attempt to reconquer the world. Von Gebsattel similarly speaks of a fight against the ‘unworlding’ (*Entweltlichung*) of the world. However, if one does not get past the stage of labour, and does not succeed to act in the sense of participating in a community, one thus cannot ‘actualize one’s freedom’ as Arendt calls it. This is exactly what Von Gebsattel notices: being busy all day with their compulsive activities, patients do not partake in the ‘real life’. Social participation is after all the least controllable of activities. In this way, patients obstruct their own self-realization. This fits with the fact that typically, in severe OCD patients, social isolation is one of the most characteristic traits, and the most difficult to treat.

Summary

Several defining and distinguishing characteristics emerge from this debate. First of all, patients suffer from recurrent thoughts or images that upset them and which they cannot control, and / or they perform certain activities that they acknowledge to be senseless. This acknowledgment or insight means that patients do not have delusions. Moreover, the insight in their condition goes hand in hand with their experience of shame. As a result, patients make every effort to conceal their problems to others, and will usually come for help only at a late stage. It is also apparent that the specific contents of thoughts and kinds of activities may vary widely. Still, the structure of their experiences is the same. The psychopathologists reported the anxiety that patients experience: some regarded it as the basic feature of this condition; others judged it to be a secondary phenomenon. There has also been debate about the role of the will and of the course of thoughts: is these patients’ will too weak to control their thoughts, or are their thoughts of such an unusual kind that the will is no match for them? In any way, patients experience themselves as unfree.

Concerning the phenomenology of the disorder, Janet added the observation that patients suffer from a feeling of incompleteness. Von Gebsattel highlighted the role of disgust and fear of decay and chaos and the patients’ experience of their worlds as unsafe. He also points to obstruction of self-actualisation that is implicated in the patients’ behaviour.

IV. Open questions & suggestions for answers

Our historical overview has shown a quest for determining the primary or basic nature of OCD: is it a disorder of the will, of emotions, or rather of the course of thinking? All three conceptions have their limitations. It is obvious that anxiety and tension play an important role in the development and sustenance of the disorder – but is it primary? One could still ask where this anxiety comes from. Here, the proponents of a more ‘cognitive’ understanding of OCD do have a story to tell: the anxiety is secondary to the abnormal course of thinking. And compulsions in

turn develop because of the anxiety aroused by the obsessions. Although this analysis of the reactive nature of compulsions indeed seems to be true for the majority of patients, one might again ask where the obsessions come from. Are they the result of a weakness of the will after all, as Esquirol thought? Indeed, patients attempt to keep their obsessions and compulsions under control and fail. But should we explain this as a lack of will power or rather as an erroneous attempt?

Little attention is paid to the fact that our normal course of thinking is characterized by a very limited amount of control. In other words, it is only natural that our stream of consciousness unfolds without conscious steering or control. Sometimes we will direct our thoughts explicitly to a specific topic, but even then, it is more like a funnelling of the thoughts, than that we actually steer or control them [24]. Moreover, it is just as normal that our attempts to exert control over our thoughts in fact end up being counter-productive. As Dagonet pointed out in 1875: ‘the more one tries to discard an idea, the more it becomes imposed upon the mind, the more one tries to get rid of an emotion or tendency, the more energetic it becomes’ [12]. Or as we now would say: anything you pay attention to will grow. This is a common mechanism too, nothing unusual. Consequently, popular definitions such as the one by Kurt Schneider – ‘Obsession is when someone can not repress contents of consciousness although he judges them as being nonsensical or dominating for no reason’ [5] (p.292) – seem to miss an important point. Namely, the problem is not the inability to repress thoughts or images (we are all bad at that), but rather the wish or even need to try to do so.

Thoughts and images (even repulsive ones) pop up all the time – that is normal. So how come these images and thoughts gain such force and cause such anxiety? It seems that patients attach much more value to these images and thoughts. In fact, having inappropriate thoughts or fantasies alone does not yet make for an obsession. It is only when one starts to worry excessively *about* having these thoughts that obsessions develop. Obsessions thus depend on the *attitude* of persons to their unwanted thoughts and images. Instead of discarding them as mere silly fantasies, patients assume that these images and thoughts reveal something about them: might they be a memory? Or do they reveal what I actually want to do if I would let myself go? How can I know for sure that I won’t do all these terrible things? Or have not already done them? Otherwise, why would I have these ideas and images?

And yet again, we may ask why patients would attach too much value to their images and thoughts. Why would I shrug my shoulders over a sexual or aggressive fantasy and do away with it as merely a fantasy – as opposed to someone who believes these fantasies convey something about who they really are? It might be that patients are less able to compartmentalize: that is, to tolerate parts of themselves that are at odds with their general self-concept. In other words: we normally succeed to ignore the incoherencies between what we think and do and our image of who we are.² More in general, as Denys [6] points out, patients suffering from OCD seem to have difficulties in tolerating uncertainty. This was already apparent from one of the first characterisations of this condition as ‘*maladie de doute*’. What bothers them is that they cannot be *absolutely* certain whether or not their thoughts may be revealing something after all, or whether or not they might get infected, or whether or not they infected somebody else. They feel they

² This explanation was suggested to us by Prof. Martin Stokhof, personal communication.

cannot be entirely sure, and this feeling of uncertainty is tantamount to experiencing tension.³ In OCD, there is a desire for *absolute* certainty.

Certainty and trust

The experiences of patients with OCD reveal how much we usually take for granted. We do not consider every possible worst-case scenario before we take action, we are blissfully oblivious to all the germs and bacteria that surround us, we ignore things we do not fully understand and accept that we make mistakes. As one patient blurted out: ordinary folks are so superficial! They do not think about anything! Normal people are blissfully ignorant. They just go about doing things, without properly investigating all the risks involved! Although he was fairly invalidated by his compulsions and longed for a normal life, he was at the same time ambivalent whether he would want to be ‘cured’ if that would entail becoming just as superficial – which puts him at the border between OCD and OCPD.

Moreover, patients’ experiences also make clear that the uncertainty at stake in OCD goes much deeper than a temporal lack of knowledge. In fact, knowledge will in general not help much. Suppose one worries whether one could get diseases from sitting on a toilet. Many people would not even consider this possibility, but suppose one does, one could look for information on the internet, or more reliably, ask an expert. Some patients indeed search for assurance in this way. But if it helps at all, it will not last. For who knows, the expert may be wrong. Experts may disagree: whom to trust? Even of so-called facts, commonly accepted pieces of knowledge, one cannot be entirely sure, for even these facts may need revision once in a while. Even scientific facts are only true within a particular paradigm. What patients suffering from OCD lack is not so much knowledge, but trust. Knowing the facts does not suffice: one still needs to surrender to them in daily life.

In his book ‘On certainty’, Wittgenstein [26] points to the difference between knowledge claims (facts) and well-founded yet unexpressed basic assumptions: we can have knowledge about certain facts, but in the end, these facts are founded on basic assumptions which are grounded in socio-cultural practices. Without doubt we normally presume these basic assumptions, which are typically not articulated linguistically, and act upon them: ‘The assumption ... forms the basis of action, and therefore, naturally, of thought.’ (Wittgenstein, OC 411, see also OC 134). Interestingly, Wittgenstein states that doubting is only meaningful with regard to facts or knowledge claims – but not with regard to basic assumptions. We suggest that doubting basic assumptions is indeed not doubt proper: it is rather a form of anxiety. Doubting

³ Of course, the question remains where this uncertainty then comes from, but this is a question at a different etiological (causal) level of analysis. Several hypotheses could be formulated, for instance that these patients’ sense of agency is disturbed as a result of disordered feed-forward mechanisms. But the quest for finding THE primary root or cause of the disorder could lead to a continuous shift of the etiological question. We would like to point out that the development of a complex psychiatric disorder like OCD may well consist of several, mutually influencing processes, rather than just one primary, common cause of everything. We therefore sympathize with recent network approaches to psychiatric disorders. See for instance: 25 Cramer AOJ, Waldorp LJ, van der Maas HLJ, Borsboom D: Comorbidity: A network perspective. *Behavioral and Brain Sciences* 2010;33:178-193.

facts is normal, doubting basic assumptions is either philosophy or pathology.⁴

Wittgenstein gives the following example, highlighting the difference between doubting a fact and doubting a basic assumption:

“If the water over the gas freezes, of course I shall be as astonished as can be, but I shall assume some factor I don’t know of, and perhaps leave the matter to physicists to judge. But what could make me doubt whether this person here is N.N., whom I have know for years? *Here doubt would seem to drag everything with it and plunge it into chaos.*” (Wittgenstein, OC 613, our italics).

If I start to doubt something as basic and fundamental as the identity of my friend, then innumerable things normally taken for granted will become uncertain as well. If I doubt *that*, what can I still rely on? The ensuing world would indeed resemble the unsafe world that Von Gabsattel described. Wittgenstein emphasizes that normally we simply do not doubt these basic assumptions: we rather unreflectively trust that these are my two hands, that my friend is the same person as he was yesterday, and that the ground beneath us will not disappear. One needs a foundation of trust in order to even be able to doubt specific knowledge claims.⁵ From this perspective, the experience of the unsafe world that Von Gabsattel described is the phenomenological counterpart of an individual who lacks the foundation of trustful reliance on the practices that we normally take for granted; on the ‘basic assumptions’ of our socio-cultural practices.

Moreover, Wittgenstein points out that ‘doubting’ such a basic assumption would have spill-over effects and could undermine one’s whole framework of everyday assumptions. We would loose the ground of our actions and thoughts. This is expressed in a different example:

“If I wanted to doubt the existence of the earth long before my birth, I should have to doubt all sorts of things that stand fast for me.” (Wittgenstein, OC 234).

‘Doubt’ would not come to an end and chaos would result, Wittgenstein suggests. Could it be that the OCD undermines some basic assumption that has a spill-over effect on the person’s whole fabric or “nest” (Wittgenstein, OC 225; cf. OC 134) of assumptions, inducing anxiety?⁶

⁴ Wittgenstein points out that there is no ‘sharp division’ (OC 97) between what counts as a ‘fact’ and what as an ‘assumptions’. He uses the metaphor of the flowing river and the riverbed: the knowledge claims are changeable like the water of the river, but even the ‘river-bed of thoughts’ (OC 97) may shift at some point.

⁵ Wittgenstein distinguishes between a subjectively experienced or ‘psychological’ certainty and certainty in a logical sense (OC 447, 448). The former applies to specific knowledge claims, the latter to basic assumptions.

⁶ Again, it is a different kind of question where the pathological doubt that undermines this basic trust comes from. How come that these patients’ basic trust is eroded? Is there a very basic perceptual process that is disturbed? And how would that have come about? These are questions at another, etiological, causal, level of analysis. Amongst other things it requires an investigation of (and comparison with) the nature of normal unreflective, trusting action.

Wittgenstein's distinction between facts and basic assumptions clarifies why knowledge of the facts does not help to reduce the compulsions of OCD-patients: the anxiety that motivates the compulsions concerns the *assumptions* rather than the *facts* of our existence. If our acceptance of the facts rests upon our trust in our basic assumptions, what can we say about where this trust comes from? Is this trust then completely unfounded? No, says Wittgenstein, there is a ground for our trust, namely the way in which we act: 'Why do I not satisfy myself that I have two feet when I want to get up from a chair? There is no why. I simply don't. This is how I act.' (Wittgenstein, OC 148). Our daily practices form both the foundation and the affirmation (OC 509) of our trust. We trust on the basis of our practical familiarity.

The problem for patients with OCD is that they want to attain absolute certainty whereas the experience of certainty can never be absolute, but will always depend on basic trust. They are right that we can never be sure that some disaster could happen, or that we might cause an accident, or that someone might be offended by something we say. Indeed, one cannot be absolutely certain about these things: we need to trust in that which we can never be entirely certain of. As a consequence, the striving for certainty via the acquisition of factual knowledge is doomed to fail. Both certainty and meaningful doubt depend on the acceptance of the possibility of the truth, which requires trust rather than science.

The role of reflection

The patients' striving for certainty via the acquisition of facts is thus an unattainable goal and unfortunately, the attempts to reach it via conscious control even have opposite effects. Their experience of uncertainty prompts them to pay extra attention to their actions: to remain conscious of all their movements rather than thoughtlessly repeating an old habit. This is a normal reaction: for instance when you go on vacation, you will make sure that you very deliberately locked the door, so that you won't have to worry about it later. But normally, such deliberately controlled actions are the exceptions and unthinking performance of habits is the norm. For people suffering from OCD it is the other way around: reflective deliberation becomes the norm. As the disorder worsens, fewer activities can be performed spontaneously: conscious control colonizes the bodily know-how.

In OCD, the balance between unreflective action and reflective deliberation is disturbed: patients think all the time (mostly of what might go wrong) and constantly try to pay attention to what they are doing. This is not some form of enlightened 'mindfulness', but rather an extremely tiresome and stressful attempt to attain maximal control over things. Such exaggerated reflection and deliberate attention to what you are doing is called 'hyper-reflectivity'. Every act becomes a conscious, deliberate decision instead of just a spontaneous reaction. What is normally taken for granted, unthinkingly relied upon, is now brought to awareness. As Fuchs [27] points out, making such tacit processes explicit actually disturbs their functionality. In other words: too much reflection undermines trust. Fuchs [27] writes: 'Self-centeredness and hyperreflection are thus, on the one hand, the result of the illness, but on the other hand, they often additionally contribute to it.' (p. 239).

This process of hyper-reflection can be recognized in many different forms of psychopathology – in fact it was first described with regard to schizophrenia [28-29]. In the case of OCD patients, we can also see such a negative spiral at work. As Denys [6] points out:

‘Typically, someone suffering from OCD will attempt to gain absolute control by total conscious awareness that, ironically, only leads to more dyscontrol’ [30]. We propose to call this mechanism the ‘hyper-reflectivity trap’. It proceeds through several stages:

1. First, there is the feeling of uncertainty, anxiety, or tension.
2. This feeling leads to attempts to regain control through deliberation (What might go wrong? How could I prevent that?), and reflective action (trying to perform all actions with maximal attention).
3. But too much reflection can be dangerous: analyzing and paying attention to your actions may lead to estrangement and typically *augments* insecurity.⁷
4. As a last step, the increase of insecurity brings us back to the first step.

Too much reflection thus disturbs the balance that is required to feel in control and it may even lead to a negative self-reinforcing spiral of feelings of anxiety and insecurity and subsequent attempts of reflective control. As we can see from the experiences of OCD patients, getting a grip on things requires letting go as well – and trust in one’s unreflective actions.

V. Conclusion

In this chapter we gave an overview of current and historical conceptions of the nature of obsessions and compulsions. We also discussed some open questions and added some phenomenological suggestions of our own. In particular, we pointed to the patients’ need for absolute certainty and the lack of trust underlying this need. Building on insights from Wittgenstein, we argued that the kind of certainty the patients strive for is unattainable in principle via the acquisition of factual knowledge. Moreover, we suggested that the patients’ attempts to attain certainty are counter-productive as their excessive conscious control in fact undermines the trust they need.

VI. References

- 1 Wegner DM, Schneider DJ, Carter SR, White TL: Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology* 1987;53:5.
- 2 Abramowitz JS, Tolin DF, Street GP: Paradoxical effects of thought suppression: A meta-analysis of controlled studies. *Clinical Psychology Review* 2001;21:683-703.

⁷ Research on memory shows that patients with OCD do not have memory impairments per se, but rather *distrust* their memory: it is thus the attitude towards their memory that is affected. Interestingly, the same happens to normal controls who are instructed to repeatedly check their tasks. The checking thus augments the feeling of insecurity. See: 31 Van den Hout M, Kindt M: Repeated checking causes memory distrust. *Behaviour Research and Therapy* 2003;41:301-316.

- 3 American Psychiatric Association: Diagnostic and statistical manual of mental disorders, 4th edition dsm-iv-tr (text revision). Washington, DC, American Psychiatric Association, 2000.
- 4 Denys D: Obsessionality & compulsivity: a phenomenology of obsessive-compulsive disorder. *Philosophy, Ethics, and Humanities in Medicine* 2011;6:3.
- 5 Bürgy M: Psychopathology of obsessive-compulsive disorder: A phenomenological approach. *Psychopathology* 2005;38:291-300.
- 6 Denys D: On certainty: Studies in obsessive-compulsive disorder. Utrecht, 2004,
- 7 Stein DJ, Fineberg NA, Bienvenu OJ, Denys D, Lochner C, Nestadt G, Leckman JF, Rauch SL, Phillips KA: Should ocd be classified as an anxiety disorder in dsm-v? *Depression & Anxiety* (1091-4269) 2010;27:495-506.
- 8 Leckman JF, Denys D, Simpson HB, Mataix-Cols D, Hollander E, Saxena S, Miguel EC, Rauch SL, Goodman WK, Phillips KA, Stein DJ: Obsessive-compulsive disorder: A review of the diagnostic criteria and possible subtypes and dimensional specifiers for dsm-v. *Depression & Anxiety* (1091-4269) 2010;27:507-527.
- 9 Hollander E, Kim S, Khanna S, Pallanti S: Obsessive-compulsive disorder and obsessive-compulsive spectrum disorders: Diagnostic and dimensional issues. *CNS spectrums* 2007;12:5-13.
- 10 Chamberlain S, Fineberg N, Blackwell A, Robbins T, Sahakian B: Motor inhibition and cognitive flexibility in obsessive-compulsive disorder and trichotillomania. *American Journal of Psychiatry* 2006;163:1282-1284.
- 11 Association AP: Proposed revision of ocd in dsm-v, 2012,
- 12 Berrios GE: Obsessive-compulsive disorder: Its conceptual history in france during the 19th century. *Comprehensive Psychiatry* 1989;30:283-295.
- 13 Griesinger W: Ueber einen wenig bekannten psychopathischen zustand vortrag. *European Archives of Psychiatry and Clinical Neuroscience* 1868;1:626-635.
- 14 Esquirol E: Des maladies mentales considérées sous les rapports médical, hygiénique et médico-légal. J.B. Baillière, 1838.
- 15 Morel BA: Du délire émotif. Névrose du système nerveux ganglionnaire viscéral. P. Asselin, 1866.
- 16 Hovens H: Geschiedenis van de diagnose obsessieve-compulsieve stoornis; in Denys D, de Geus F (eds): *Handboek obsessieve-compulsieve stoornissen*. Utrecht, De Tijdstroom, 2007, pp 1-13.
- 17 Von Krafft-Ebing R: Beiträge zur erkennung und richtigen forensischen beurteilung krankhafter gemütszustände für ärzte, richter, und verteidiger. Erlangen, Enke, 1867.

- 18 Westphal C: Über zwangsvorstellungen. Archiv für Psychiatrie und Nervenkrankheilkunde 1878;7:734-750.
- 19 Janet P: Les obsessions et la psychasthénie. Paris, Alcan, 1903.
- 20 Pitman RK: Pierre Janet on obsessive-compulsive disorder (1903). Review and commentary. Archives of General Psychiatry 1987;44:226-232.
- 21 Von Gebsattel VE: Die welt des zwangskranken; Prolegomena einer medizinischen anthropologie. Berlin, Springer, 1954
- 22 Glas G: Angst. Beleving, structuur, macht. Amsterdam, Boom, 2002.
- 23 Arendt H: The human condition. Chicago, 1958/1998.
- 24 De Haan S, De Bruin L: Reconstructing the minimal self, or how to make sense of agency and ownership. Phenomenology and the Cognitive Sciences 2010;9:373-396.
- 25 Cramer AOJ, Waldorp LJ, van der Maas HLJ, Borsboom D: Comorbidity: A network perspective. Behavioral and Brain Sciences 2010;33:178-193.
- 26 Wittgenstein L: On certainty. Oxford, Blackwell, 1975.
- 27 Fuchs T: The psychopathology of hyperreflexivity. The Journal of Speculative Philosophy 2011;24:239-255.
- 28 Laing RD: The divided self, ed 1990 (incl. 1965 preface). London, Penguin Books, 1959/1990.
- 29 Sass LA, Parnas J: Schizophrenia, consciousness, and the self. Schizophrenia Bulletin 2003;29:427-444.
- 30 Denys D, Prosée R, Stein D: Obsessive-compulsive disorder and Certainty; in Phenomenological Neuropsychiatry: How Patient Experience Bridges Clinic with Clinical Neuroscience (eds): Mishara A, Corlett P, Fletcher P, and Schwartz M, New York, Springer (*in press*).
- 31 Van den Hout M, Kindt M: Repeated checking causes memory distrust. Behaviour Research and Therapy 2003;41:301-316.