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How obsessive doubts about the past differ from ordinary ones

GHERARDO MANNINO[1]

[1]Dipartimento di Salute Mentale, Azienda Sanitaria Locale Roma 1.

Summary. Obsessive-compulsive disorder (OCD) still presents several enigmatic aspects, especially when viewed only from a third-person perspective. Instead, things become more comprehensible if we try to reconstruct the patient's first-person point of view. In this paper, an analysis of obsessive doubts about the past, illustrated by clinical examples, allows us to show that obsessive doubts, unlike ordinary ones, do not arise from insufficient knowledge of what happened. Instead, they seem to arise from the fact that OCD patients perceive all the mental images in which a feared event occurs as a sort of window open to a possible world. So that the authentic drama of an OCD subject is that he/she will face every time an array of possible worlds without knowing which of them is the real one. Furthermore, a comparison is made between the hypothesis presented in this paper and one of the best-known models in the literature: the hypothesis of 'inferential confusion'. Finally, some implications for psychotherapy of OCD are discussed.

Key words. Doubts, epistemic, inferential confusion, obsessive-compulsive disorder, ontological, possible worlds.

Come i dubbi ossessivi sul passato differiscono da quelli ordinari.

Riassunto. Il disturbo ossessivo-compulsivo (DOC) presenta ancora diversi aspetti enigmatici, soprattutto se osservato solo da una prospettiva in terza persona. Invece, le cose diventano più comprensibili se proviamo a ricostruire il punto di vista in prima persona del paziente. In questo lavoro, un'analisi dei dubbi ossessivi sul passato, illustrati tramite esempi clinici, permette di mostrare che i dubbi ossessivi, a differenza di quelli ordinari, non nascono da una conoscenza insufficiente di ciò che è accaduto; infatti, essi sembrano invece nascere dal fatto che tutte le immagini mentali in cui si verifica un evento temuto sono percepite dal paziente come una sorta di finestra aperta su un mondo possibile. In modo che il dramma autentico di un soggetto con DOC consiste nel fatto che egli/ella si troverà a fronteggiare ogni volta una serie di mondi possibili senza sapere quale di essi sia quello reale. Inoltre, viene condotto un confronto tra l'ipotesi presentata in questo lavoro e uno dei modelli più noti in letteratura: l'ipotesi della "confusione inferenziale". Infine, vengono discusse alcune implicazioni per la psicoterapia del DOC.

Parole chiave. Confusione inferenziale, disturbo ossessivo-compulsivo, dubbi, epistemico, ontologico, mondi possibili.

Introduction

One of the most characteristic phenomena of obsessive-compulsive disorder (OCD) has always been considered the so-called 'pathological doubt'. In fact, before it took its current name, this disorder was called 'folie du doute' (that is, the 'madness of doubt') by the French School of the late nineteenth century[1]. Even nowadays, pathological doubting is considered an important feature of OCD and, moreover, it appears strongly associated with global impairment[2].

Obsessive doubts can concern choices and therefore result in considerable decision uncertainty[3,4], but often they regard facts: i.e., doubts about whether an action has been performed correctly or whether a negative event has occurred in the past. Therefore, the term 'pathological doubt' refers especially to those patients who are very worried that – due to their presumed negligence – they may end up damaging themselves or others; from these worries exhausting control rituals usually arise.

However, obsessive doubts differ from the common doubts of daily life not only because of their greater frequency and intensity. In fact, they also seem to possess peculiar characteristics that make them quite different from ordinary doubts. Some of these features have already been described in the literature, although perhaps they have not always received all the attention they deserve.

For example, a simple feature, apparently obvious, but quite important, is that OCD people have very selective doubts: in fact, these always appear connected to issues that already deeply concern the patient[5]. In fact, as rightly stressed[6], an OCD subject might wonder whether his hands are clean or whether the front-door is really closed but, for example, he/she usually does not ask himself/herself whether the bus that just passed is really the 39. Unless, of course, the question is of particular significance in the context of his/her concerns. This selectivity makes it very unlikely that obsessive doubts derive from a real memory problem as hypothesized in

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a recent past: in fact, some researchers, years ago, asked themselves whether OCD people repeat their checks because they do not remember having just done it or do not remember the result of it. Consequently, since the early nineties, a whole series of research began with this issue[7]. However, the most recent research does not confirm the role, in doubting and checking, of a true deficit of memory. Rather it highlights some different problems: for example, a reduction in the confidence that OCD people have in their memory in situations where perceived responsibility is high[8] as well as the interference on memory exerted by stress and heightened attention on obsessive thoughts[9]. In conclusion, the research seems to bear witness to what the simple consideration of the selectivity of the doubts had already allowed to guess.

This demonstrates the usefulness of a prior analysis in better defining the characteristics of the object of investigation before embarking on empirical research[10]. Not only that: an analysis of patients' first-person experiences, inaugurated by phenomenology, allows us to reconstruct the world as he/she sees it as well as the difficulties he/she encounters in living in it. In fact, it is difficult, for example, to put in place a targeted and effective psychotherapeutic intervention if an idea of the patient's problem is not yet available.

Given the large variety of obsessive doubts, to simplify the task we have chosen a specific kind of obsessive doubting: the doubts about actions that the patient could have performed (or missed to have performed) in the past. Therefore, the aim of this paper is to consider obsessive doubting about the past in order: first, to illustrate some important features of it; secondly, to use these features to try to better clarify its deep nature.

To achieve these goals, naturally it does not seem indicated to resort to the classic clinical cases described in the third person. In fact, in a case of this kind, the theories of the clinician will inevitably influence the exposure of the case itself. For this reason, we have chosen instead to use brief first-person reports, thus resorting to the words of the patient himself/herself.

Two important features of obsessive doubts about past

A first characteristic of obsessive doubts, already described in literature[5], has to do with the relationship between the doubts and the events that apparently raise them. To illustrate this aspect, a clinical example is useful.

Clinical example 1

A 30-year-old woman, affected by OCD, reports that, among the disturbances that afflict her, there are very tormenting doubts about presumed reprehensible actions she would have committed in the recent past. Her following words refer to an episode in which she was suddenly assailed by an obsessive doubt:

"I am driving along the road at 60 km/h. I am going to visit my family who live outside, for the weekend. Dawn has just broken, and the road is still completely deserted. Suddenly, out of nowhere, I have the terrible doubt that I could have hit a passer-by without realizing it".

Of course, the patient, after a moment of upset, seems soon to regain a sense of mastery, because she in some way knows that she has not run over anyone. However, this reassurance does not last long because a corrosive anxiety arises in the woman at the idea of having really committed a possible action of unforgivable negligence. Then the patient, at this point, thinks that – even if from the beginning of the doubt has already traveled a few hundred meters – the only way to allay the anxiety is to go and check the place of the presumed accident.

Therefore, a first peculiarity of the 'pathological doubt' seems to consist in this: that an OCD subject – at least in most cases – does not have a doubt about an event that really happened; doubts, instead, follow an only imagined one[5]. In fact, if someone had really hit something or someone with his car, he/she would be allowed to wonder how or where this happened. However, this is not what usually happens to an OCD subject: here, indeed, doubts do not follow an event that really happened; doubts, instead, follow an only hypothetical one. In other terms, «the person reacts not to what is there, and not even to the exaggerated consequences of what is there, but to what might possibly be there even though the person's senses say otherwise»[5]. In other words, a doubt usually follows an event that really happened (for example, "I no longer find the car keys and, consequently, I doubt whether I have left them at home"). So, first an event, then the doubt; the opposite happens in OCD people: first, a doubt comes unexpectedly, then the subject looks for a hypothetical event that justifies it.

This peculiarity of the obsessive doubt is even more evident if one makes a comparison with what happens during an investigation in the case of an established crime. Here, in fact, the sequence is this: at the beginning, there is a fact that really happened; therefore, the investigators, guided by possible scenarios, proceed to a reconstruction of the events; finally, they arrive at the identification of the possible culprit. In the case of OCD, instead, the sequence is completely different and decidedly paradoxical: at the beginning, of clear and established there is only the sudden intuition on the part of the patient of the possible culprit, in the form of a mental image of a

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reprehensible action committed by himself/herself. Then, a plausible reconstruction of the events appears in the patient's mind; and only at the end – this is a fundamental point – the patient goes to check if the 'crime' really happened.

Let us look now at the second characteristic of pathological doubt, which is not already present in literature. It precisely concerns the space-time collocation of the presumed events to which the doubts refer. To illustrate this characteristic, it is useful again to draw on a first-person account, always taken from the same clinical case. In fact, under the pressure of the doubt that torments her, the patient goes back to check whether what she fears has really happened or not. She illustrates well this moment with these words:

"I turn the car around and go back to the scene of the presumed accident, at the point on the road where I think that it might have occurred. Of course, there is nothing: no ambulance and no bloody body. Relieved, I leave for my destination".

It is useless to say that the patient manages to drive serenely only for a while, because her mind is soon crossed by a new doubt:

"Maybe – I think – I didn't go back far enough on the road and the accident happened a kilometer or two earlier".

Therefore, the second characteristic of the obsessive doubt seems to consist in this: that the patient will repeat the *doubt-reassurance-new doubt* sequence with a difference each time. Obviously, the aspect that appears important here is not the repetition of the check (a well-known feature of OCD), but the fact that with each new check the subject introduces a difference. In fact, after that the check (related to a given scenario) has been carried out, the new scenario that, after a momentary reassurance, comes to the patient's mind, is inevitably a little different from the previous one. That is, if at the beginning the patient thinks that the accident may have occurred half a kilometer before the point where the doubt (whether she had hit someone) arose for the first time, once she, by means of a check, has ruled out this occurrence, that version of the facts is abandoned. Therefore, the new doubt that appears in the patient's mind could be at this point that the accident occurred one kilometer before, or two or five; or, perhaps, even the day before, and so on. In other words, as soon as she has carried out a check that excludes the feared possibility, the patient cannot refrain from imagining a somewhat different story and, at least in part, alternative to the previous one.

This feature may be less recognizable when the disorder has been around for a long time and the checking behaviors have now turned in an automatized habit, but it is easily identifiable at the outset. Even here, to better illustrate this phenomenon, a comparison with what happens with an ordinary investigation for a crime can be useful. In fact, even in this case it can happen that the investigators go several times to the 'scene of the crime' to collect new clues, examine aspects previously overlooked or to proceed with new verifications. However, this is not the case in the 'pathological doubt' of OCD: here, indeed, it is as if the patient was exploring during subsequent controls, not different parts of the same 'crime scene', but rather 'crime scenes' different from each other, often located in different places and times.

This may be difficult to believe, especially when the subject repeats his/her checks in the very same place. However, on closer inspection, it is easy to find that this is the case. Let us think, for example, of a man with OCD who, as soon as he got to bed after checking the front door, was assailed by the doubt of not having locked it. Now, once he carried out a check and returned to bed again, if the doubt reappears, this will probably have a shape at least a little different from before, given that the previous scenario (of not having locked the door) – strictly speaking – has been excluded from the previous check. For example, this time the patient may think he has not closed the door with two turns of the key. And if the patient, once again at bed after the new check, is assailed by a new doubt? Well, it is likely that it still changes form again; for example, the patient might ask himself: "Will I have checked that the lock was not loose?". So, every time he imagines a 'version of facts' that is a bit different, and even the guilty negligence in his eyes will result, by force of circumstances, each time a little different.

So, even if the patient's controls always revolve around the same physical entity – in this case the front door – this should not overlook the fact that the patient is exploring different scenarios and different versions of the facts every time.

We can conclude by saying that we need to keep in mind two important features of obsessive doubts about the past: 1) the doubts do not follow a real event, rather they themselves create a hypothetical event; 2) the imaginative scenarios, which raise the doubts, are placed in space-time contexts, each time at least a little different.

The nature of obsessive doubts

If we consider together the two characteristics illustrated above, it appears clear that the doubt hosted by an OCD subject is not a properly an epistemic doubt (from the Greek word *epistḗmē*: 'scientific knowledge'). In fact, we can consider epistemic a doubt that arises from an imperfect knowledge of

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a certain state of affairs: that is to say, a given event certainly occurred, but doubts arise about it, because the details are not well known. Consider, for example, the case of a person who lost his/her wallet. This person knows for sure that at a certain point some event about his/her personal effect must have really happened (for example, the wallet was stolen, or it fell while he/she was sitting at a café), and he/she knows for sure that this event must have occurred in a certain place and within a certain time interval. What is missing is only the knowledge of the exact way in which it occurred.

Instead, as we have already seen before, it is evident that the obsessive doubts seem quite different. In fact, they do not concern the greater or lesser knowledge of a certain situation; rather they consist in wondering whether a given situation has ever really been part of the world. In fact, for example, there is an important difference between not knowing how to reach a place (an epistemic problem) and not knowing whether that place really exists (an ontological problem). Let us remember here that ontology (from the Greek word *òntos*: 'what exists') is the branch of human reflection that questions itself precisely about what exists and about the different ways of existing of different entities[11]. From this point of view, it would be more correct to define obsessive doubts as ontological doubts.

At first, one might think that these philosophical distinctions (i.e., epistemic *versus* ontological) should remain extraneous to a scientific discussion; in reality, they are often necessary. Let us think about what happens in one of the more rigorous sciences: physics. In fact, researchers once thought that the impossibility of defining exactly the position of elementary particles depended on an imperfection of their measuring instruments (*epistemic issue*). Now, instead, it is becoming increasingly clear how the behavior of elementary particles is inherently different from that of macroscopic objects and that lack of localizability of particles is an intrinsic feature of the matter (and therefore of the world) at a submicroscopic level (*ontological issue*)[12].

Returning to OCD, we can see how the peculiar ontological nature of obsessive doubts is even more evident from the following suggestive clinical example, taken from an educational book on obsessive disorder[13].

Clinical example 2

A graduate student in English literature once, under the pressure of considerable anguish, went to the police station at six o'clock on Sunday morning to confess a presumed murder: "Where is the body?"; "I'm not sure"; "How was the murder committed?"; "Well, I might have pushed someone off the bridge"[13].

Now, a person, knowing that he/she has lost his/her wallet, but not where and when it occurred, will try to reconstruct what happened by exploring different possibilities; of course, these possibilities cannot all be true (only one of them is), but they refer to a single world: the one in which the person no longer finds his/her wallet. Instead, if a man does not know whether he has thrown a person from a bridge or not, in a certain sense he is talking about two different worlds: the one in which that fact occurred and the one in which it did not happen. But why are we using the term 'world' in the plural? In fact, is not the world only one? To understand this point it is useful to start from a simple definition of our world: a consistent and inclusive whole, which contains everything that exists, with a definite past and an open future (though certainly influenced by what happened in the past). However, things might have been different in many ways: for example, because only some events of the past went differently from our world or because there are laws of nature different from ours[14].

Thus, it is possible to think – at least at a theoretical level – of other possible worlds, equally inclusive and complete worlds like ours but in some respects different from it.

It is important to underlie that the concept of 'possible worlds' is a common topic in contemporary philosophy, although with an extreme variety of points of view[15]. For example, for some authors, 'possible worlds' are a simple fiction[16] while for others they are as real as ours is[14]. Even if most scholars do not share the latter position, nevertheless, specialists hold the concept of 'possible worlds' in high regard because it has made it possible to reformulate problems that are otherwise difficult to treat in simple and elegant terms, thus allowing an extremely important progress in disciplines such as logic and computer science[15].

In any case, these theories all look at the 'possible worlds' from a third-person perspective, typical of science. Bruner[17] highlights this fact when he compares paradigmatic thought, typical of science, with narrative thought, typical instead of the reports of everyday life. In fact, domain of paradigmatic thought «is defined not only by observables to which its basic statements relate, but also by the set of possible worlds that can be logically generated and tested against observables».

Here, instead, we are interested in the concept of the world from a first-person perspective. Consequently, the possible worlds of which we speak are in any case worlds at the center of which the subject is always found.

With these concepts in mind, we can precise what seems to happen in the doubts examined here. When a mental image of some feared event comes to an OCD subject's mind, the subject is faced with two distinct hypotheses of the world, both perceived as

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equally possible: the one in which that feared event occurred and the one in which it did not happen. At this point, the problem is that he/she does not know which of the two hypotheses of world (that is, the two 'possible worlds') is the real one.

From this perspective, taking up the first clinical example, we can understand how, from the point of view of the patient, there is a first world (consistent and plausible) in which she has run over no pedestrian. As well as there may exist a 'world two', equally complete and consistent but alternative to the first, in which she has hit a passer-by, let us say at kilometer five of the way. Moreover, once that the subject has excluded by means of checks that 'world two' is true, in her mind a 'world three' will emerge, in which instead she has hit a pedestrian decidedly earlier, for example, at kilometer three; and so on. At this point, it is evident that the authentic drama of an OCD subject seems to consist in the fact that, among these possible alternative worlds, he/she does not know which the real one is. For the same reason he/she feels the need to explore every possible scenario/world that contains the feared event: to be sure that it is not the real one. In fact, any mental image of a feared event discloses a new world, perceived to all effects as a realistic possibility, no matter how implausible. In addition, the fact of having discovered it makes the subject obliged to explore it; otherwise, he/she would be guilty of an unforgivable negligence: to have done nothing to avoid the feared event or to try to remedy it.

A comparison with what literature says

Once the analysis conducted in the present paper seems to have revealed the true nature of the obsessive doubts about the past, it becomes interesting to compare what has been found with what the literature on the subject says. In fact, a hypothesis advanced in the literature is that subjects with OCD present peculiar reasoning processes that lead them to confuse an 'imagined possibility' with an 'actual probability' based on what is perceived[5], a phenomenon that has been given the name of 'inferential confusion'[18].

Among the reasoning processes underlying the phenomenon, the so-called 'inverse reasoning' would play a key role[19,20]. Let us see what it is. A subject without OCD could reason like this: "This floor is dirty and with many footprints, so by force of things many people must have walked on it"; in other words, the subject in this case draws a deduction from a fact. A subject with OCD, on the other hand, would argue in the opposite way, drawing a deduction from a simple hypothesis, even if contradicted by the facts: "On this floor many people must have walked, so by force of things must be dirty"[18]. Consequently, while in the normal inference the subject, in the face of an evidence that contradicts the starting hypothesis, is ready to review the latter, in inverse inference, instead, he/she would keep the hypothesis firm and, if anything, would review evidence in light of the hypothesis[5].

There is no doubt that this hypothesis is certainly relevant to the phenomenon in question. However, considering the reflections carried out in the previous paragraphs, what happens in the OCD seems to be of a different nature. In fact, it does not seem to consist in the fact that an 'imagined possibility' is exchanged by the subject for 'an actual probability', but rather in the fact that the imagined scenario gives the subject a glimpse of a 'possible world' that he/she cannot exclude is the real one (table 1).

This subtle but fundamental difference between the theory of 'inferential confusion' and what is presented in the present paper, that can be named 'hypothesis of imaginable worlds', deserves to be further emphasized: in fact, the crucial aspect of what maintains the pathological doubt would not be constituted by the attribution, on the part of the subject with OCD, of some probability (even remote) to a simply imaginary event. In fact, this hypothesis is contradicted by what can easily be detected in the clinical setting and, that is, the fact that the feared event is very often perceived, precisely from the subject himself/herself, as wholly implausible (in the world shared by all) and nevertheless, at the same time, as possible (table 1). A clinical example may be useful in this regard.

Clinical case 3

A 17-year-old boy, suffering from OCD with only partial and intermittent insight, presented, among other things, a particular obsession: that performing certain actions could produce an exchange of personality between himself and some of his friends. In moments of greater insight, he described his situation with these words: "I understand by myself that what I fear is too extreme, in fact I think it is really absurd… however, I cannot exclude that it is in some way possible".

Thus, the OCD problem does not seem to lie in the fact that a merely imagined eventuality acquires a certain degree of probability. The problem, if anything, is another: that the subject cannot be certain that there is not a world in which the feared event is instead possible, and that this world is not ultimately the real world in which we all live. In other words, it is as if the subject asked himself: "Who tells me that the world is not made differently from the way we all think it is done? And if so, why in a world like this the event I fear would not be possible?".

We understand better that the patient is calling at stake, not just a particular event, but a whole world, if

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we pause to reflect on the fact that for an 'exchange of personalities between individuals' to be possible the whole world should be different from what we know it.

Ultimately, a reading in terms of imaginable worlds seems to eliminate a contradiction in the world view of OCD people as presented by the theory of 'inferential confusion': the fact that the subject would end up considering the event feared at the same time as 'too extreme to be possible' and, still, as 'probable' (table 1). Instead, if we embrace the hypothesis of imaginable worlds (which seeks to reconstruct the subject's first-person point of view of an OCD subject), it is easy to understand how the subject can perceive the imagined eventuality at the same time as apparently absurd (as it contradicts what we are used to seeing in our ordinary world), but not impossible in an imaginable world made differently, which, however, could be the real one (table 1).

Genesis of the mental images and some implications for psychotherapy

Once the nature of obsessive doubts about the past has been described, the problem remains of how to try to explain the mental images which raise those doubts.

To illustrate this aspect, let us start from the consideration of three aspects: the first one concerns the fact, underlined from some author[21], that mental images in OCD seem to be a consequence of emotional emergencies not yet assimilated. For example, a man may have a recurrent and disturbing mental image of a disease that suddenly affects his father-in-law where he works as dependent; and only later, in therapy, does he realize the anger he felt towards him is for the fact that he did not grant him the professional autonomy he believed to deserve[21].

The second aspect consists in the remarkable difficulties encountered by OCD people to decode the analog and emotional aspects of their own inner experience[21,22]. After all, a mental image can be interpreted first and foremost as a clue of the way in which a subject is feeling in emotional terms a given existential situation: for example, the image that can appear in a student's mind of failing an important exam, it should not necessarily be read as a forecast of what will happen but, if anything, it can simply be an expression of the value attributed to the examination and the desire to avoid a negative outcome[23]. Here it may be useful for us to adopt for a moment the distinction between affective information (context-related) and cognitive information (relating to the temporal and causal order of the events)[24,25]: in this way, we could say that subjects with OCD, precisely because of this difficulty in decoding the analogical aspects of experiences, tend to deal with systematically affective information (e.g. their own mental images) like if it were cognitive information, that is, possible predictions or possible memories. From here the need to carry out checks aimed at ascertaining if what is imagined really is verified.

Table 1. This table shows the main differences between the hypothesis of the 'inferential confusion' and the hypothesis of 'imaginable worlds'.

	'Inferential confusion' hypothesis	Hypothesis of 'imaginable worlds'
Brief definition of the process	An only imagined possibility is mistaken for a realistic and probable eventuality.	Impossibility of excluding that an imagined world (where the feared event is possible) is not the real one.
Mechanism involved	A particular type of cognitive distortion: 'inverse reasoning'.	Reading of affective information (a mental image) as if it were cognitive one (a memory).
Short illustration of the result	An event - just because it is thought - is considered an event with a realistic probability of happening.	The mental image of a feared event is perceived as a sort of open window to a possible world.
Explanation of compulsions	The subject tries to change at a real level what has taken shape only in the imagination: inevitably the person fails to do so, so he/she continues to insist.	The subject, with his/her checks, tries to exclude that the imagined world is the real one: he/she will repeat the rituals because, once a possible world is excluded, the subject soon considers another one.
Is the patient's point of view, illustrated by the hypothesis, consistent?	It does not appear consistent, as the patient can perceive the same event as implausible and, at the same time, as probable.	It appears consistent, as the patient cannot exclude that an event, however implausible, belongs in any case to an imaginable world (that could be the real one).

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As a result, the patient feels highly responsible for his own mental images. Wanting to simplify, it is as if the patient were saying to himself/herself: "If this image came to my mind and scares me so much, it means that there is a part of me that really wants it"[26,27]. This will help to add further vividness to mental images because the subject feels them as a profound expression of himself/herself.

In the light of these considerations, it perhaps becomes easier to understand the difficulties that even nowadays recommended psychotherapeutic interventions face in the case of OCD. For example, standard cognitive therapy seems to be effective only in a quarter of the cases[28]. To understand this fact, let us think of the case of a patient with an obsessive fear of inadvertently damaging others[6]. Main concern of a man, for example, was to have walked, without realizing it, on the glass and that a fragment had remained attached to his shoes. From here, he thought, it could have end up, through a long series of intermediate steps, in a hospital breaking a life support machine that kept a patient alive, so that a man would die because of him[6]. Some authors[29] suggest in these cases an intervention based on probability arguments and aiming at a modification of the risk assessment by the patient himself, to persuade him that the eventuality that the whole chain of events occurs is extremely remote. However, such an intervention shows a weak point: in fact, even if the patient recognizes the extreme improbability of that sequence, who guarantees that the world, in which that chain of events occurs (even if unlikely), is not precisely the real one?

In short, if the overestimation of an imaginative scenario does not actually arise from a real logical error, an intervention based only on rational arguments is not very fruitful. What could be a more productive alternative? Considering what has been said in this paper, if mental images that come into the mind of the patient are a consequence of emotional emergencies not yet assimilated, it is evident that the therapist will drive the patient to focus on these perturbing activations. Also, if mental images are read as possible memories – that is, affective information read as cognitive one – the therapist will help the patient to grasp the connection of the images with the context of the moment and with the emotional aspects of interpersonal relationships. Through an intervention of this type, the patient will finally come to grasp the value and extreme existential significance of imaginative scenarios without being any more upset.

Conclusions

In this paper an analysis of obsessive doubts about the past was conducted and by this we have discovered that for an OCD subject all imaginable worlds, where a feared event happened, are seen – at last for a moment – as 'possible worlds'. Therefore, the true drama of an OCD subject is that he/she never knows which, among all possible worlds, is the true one.

Trying to understand the first-person view of an OCD subject might seem like an academic exercise for its own sake, but it is not so since reconstructing a patient's world, just as he/she experiences it, is the first step to understand his/her problem. For example, an outside observer might find the tendency of obsessive doubts to reappear immediately after a successful check completely incomprehensible. If, instead, we take in account the first-person view of the patient, it becomes clear that the latter, whenever a new mental image appears in his/her mind, is faced with a new variant of the world: this explains why he/she feels compelled to explore this umpteenth possibility every time. If he/she did not do so, he/she would feel guilty of an unforgivable negligence: in fact, despite having a possible memory of an extremely negative fact, he/she would be responsible for not trying to repair things.

Therefore, when an OCD subject carries out checks to ascertain whether what he/she has imagined has actually occurred, it means that he/she is exploring scenarios/worlds in which the imagined fact happened. However, since the scenarios/worlds – in which the feared event may appear – are in fact infinite, one understands why the subject is compelled to perform a check after another.

Finally, it is evident that the above also has important implications for therapy. In fact, it helps to explain why some interventions, although recommended, work only partially: this happens because they act only on the patient's explicit beliefs that appear wrong to an outside observer (that is, from a third-person perspective), without modifying in any way his/her specific first-person view. From this, the need for new psychotherapeutic interventions able to take these aspects into account.

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Corresponding author:
Dott. Gherardo Mannino
E-mail: gherardo.mannino@gmail.com