**Article** *in* Philosophical Psychology · February 2016

DOI: 10.1080/09515089.2015.1130220

**BELIEF, QUASI-BELIEF, AND OBSESSIVE-COMPULSIVE DISORDER**

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***Author’s final manuscript. All citations should be to the published version.***

**1.** Jane (we’ll call her) compulsively switches the lights on and off, fearing that: “Maybe the switch is somewhere between the on and off position and a fire will start because of a short circuit. I know that this does not make sense. Still, I have to keep switching back and forth until I get it just right” (Osborn 1998, p. 41).

Raymond, a mechanic in his mid-forties, experiences images of contaminated material accidentally spilling and starting a devastating plague. He “knew rationally that this vision was figment of his imagination.” Yet the images drive him to scrutinize every inch of his house for contamination before going to work, and then to return half a dozen times to ensure that he didn’t miss anything. He is also tormented by images of contaminants spilling at his child’s school. In response, he imagines cleaning it up with a vacuum cleaner while making “whooshing” sounds (Osborn 1998, pp. 10-15).

“J. F.,” a recent medical school graduate, is troubled by “ideas that she might become contaminated by substances such as cosmetics which could have become transformed by sunlight or heat into carcinogens. . . . She was well aware of the extremely unlikely nature of [these ideas],” yet she spent “most of the day” ensuring that her cosmetics were uncontaminated by heat and sunlight, “to the point of dismantling enormous shop displays to find an unflawed packet” of cosmetics (Salkovskis 1985, 576).

Jane, J.F., and Raymond have Obsessive-Compulsive Disorder, a disease characterized by obsessions, compulsions or—most commonly—both. Obsessions are “recurrent and persistent thoughts, urges, or images that are experienced . . . at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress” (American Psychiatric Association 2013, p. 237). Common obsessions involve contamination, omitting something (like locking doors or turning off the gas) that results in disaster, images of harm befalling a loved one, disgusting or blasphemous thoughts or images, and aggressive or self-destructive urges. Compulsions are “repetitive behaviors . . . (e.g., hand washing, ordering, checking) or mental acts . . . (e.g., praying, counting, repeating words silently) which the individual feels driven to perform in response to an obsession,” and which “are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation” (American Psychiatric Association 2013, p. 237). To meet DSM-V’s criteria for OCD, the obsessions and/or compulsions must be “time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment” (American Psychiatric Association 2013, p. 237).

Like many people with OCD, each member of our trio has reasonably good “insight”: They recognize, at least sometimes, that their fear and compulsive behaviors are irrational, bizarre, or clearly excessive. Recent studies have found that approximately 80% of persons with OCD have relatively high insight (Catapano et al., 2010; Jacob, Larson, and Storch 2014). Patients in this group will be the main focus of this paper.

OCD—at least when it is accompanied by good insight— generates a philosophical puzzle. How should we describe the beliefs of someone like Jane? Her emotions and compulsive behavior suggest that she believes that an improperly flipped switch is a significant fire hazard.  Yet she purports to understand that “this does not make sense.” Moreover, Jane fails to do some things we might expect her to do if she really did believe that improperly flipped switches posed a fire hazard. She does *not* warn her friends about the dangers of improperly flipped switches, or begin a campaign to outlaw them, or bring a negligence suit against her home’s builder for installing such dangerous devices. Similarly, J.F.’s emotions and compulsive behavior suggest that she believes sun and heat can turn ordinary cosmetics into carcinogens. Yet, she purports to understand that this idea is far-fetched. She does not counsel her patients to avoid sunlight-contaminated cosmetics, or lobby the AMA to warn the public of such dangers. Finally, despite the fact that his anxiety and compulsive behavior suggest otherwise, Raymond “knew rationally that this vision was figment of his imagination.” And he hasn’t installed video cameras to monitor his home for the sudden appearance of buckets of plague, or pestered the principal of his child’s school to take similar precautions.[[1]](#endnote-1)

In short, persons with OCD may not only disavow the propositions that appear to generate their anxiety and compulsive behavior, but they may also fail to employ them as premises in their practical or theoretical reasoning. These facts challenge the commonsense notion of belief, which sees it as a propositional attitude which: (1) drives emotion and motivation, but also (2) is reported in the agent’s sincere assertions, and (3) is used in practical and theoretical reasoning.[[2]](#endnote-2)

**2.1.** Although theories about OCD go back centuries, the first to yield an effective treatment derived from behaviorism. It suggested that an initially non-threatening stimulus becomes anxiety-provoking by being connected through classical conditioning to a naturally anxiety-provoking stimulus. (Perhaps Jane once turned on the lights and saw a rat scurrying away; now she gets nervous when she flips a light switch.) Compulsive behaviors were thought to alleviate this anxiety; consequently, they would be reinforced through operant conditioning (Taylor, Abramowitz, McKay, & Cutler 2012).

This theory inspired a therapy that remains the “gold standard” today: exposure and response prevention (ERP). ERP involves exposing the patient to stimuli that trigger her obsession and the resulting anxiety and compulsive motivation, while encouraging her to avoid performing the compulsive action. Patients undergoing ERP normally find that within 1-2 hours, their anxiety and compulsive motivation dissipate. These effects usually persist after the treatment, and repeated treatments can significantly reduce OCD symptoms (Foa, Yadin, & Lichner 2012). Behaviorist theories explained ERP in terms of habituation and extinction: Prolonged exposure to the triggering stimulus gradually *habituates* the person to it, and forgoing performance of the compulsion *extinguishes* it by removing the reinforcement hitherto provided to it by its ability to alleviate anxiety.

Consider Amy, an OCD patient with washing compulsions. Amy fears that contact with contaminated surfaces will cause a “debilitating disease” (Foa, Yadin, & Lichner 2012, 85-86). Her ERP treatment includes touching various “contaminated” items, such as doorknobs, without washing. Initially, this provokes significant anxiety. Yet she voluntarily endures the anxiety and resists the urge to wash. Now, Amy’s anxiety and compulsive motivation suggests that she believes that unwashed doorknobs are biohazards. Yet her voluntarily choice to touch one without washing suggests that she believes just the opposite. Thus, OCD patients undergoing ERP manifest the puzzle of OCD in its starkest form. Their anxiety and compulsive motivation suggest that they believe the very thing that their willingness to undergo the process and resist the compulsive motivation suggests that they do not.

The details of ERP rule out certain otherwise appealing analyses of OCD. For example,we might be tempted to suggest that people with OCD simply change beliefs: believing one thing when their symptoms are present, but believing the opposite the rest of the time. However, this suggestion cannot account for the fact that persons undergoing ERP appear to believe contradictory things *simultaneously*. Or consider the suggestion (from an anonymous reviewer) that someone like Amy might straightforwardly believe that doorknobs are biohazards, while *appearing* to have good insight because she recognizes that *other people* regard this belief as unreasonable. If Amy really did believe that doorknobs harbored terrible diseases, why would she willingly undergo ERP? It is difficult to see why she would voluntarily do something she believes is so dangerous just because she knows that others do not share her belief.

**2.2.** Despite the success of ERP, behaviorist theories of OCD fell out of favor by the mid-1980s. They were replaced by more cognitive approaches, the most influential of which derives from a seminal paper by Paul Salkovskis (1985). His theory combined two important elements. One was the finding by Rachman and de Silva (1978) that people *without* OCD experience intrusive thoughts, images, and urges that are similar in content to the obsessions found in OCD. However, in persons without OCD, these intrusions are transient and cause little or no distress. By contrast, in OCD, they are more frequent, intense, and disturbing, and they are accompanied by compulsive motivation. To explain this difference, Salkovskis introduced a second element, which he derived from the work of Aaron Beck (1976). Beck argued that many mental disorders arise from “*negative automatic thoughts*” (NATs). NATs are typically unarticulated and often unnoticed by the person who has them, but they can produce anxiety and other psychiatric symptoms.

Combining these two ideas, Salkovskis theorized that in OCD, dysfunctional NATs transform ordinary intrusions into sources of debilitating anxiety and irrational behavior: “The affective disturbance usually described as arising from the obsession or intrusion actually arises from . . . automatic thoughts *about* the intrusion” (Salkovskis 1985, pp. 573-4, emphasis added). So J.F.’s intrusive thoughts about sunlight-contaminated cosmetics would trigger a NAT to the effect that “I’ll get cancer and it’ll be my own fault” (Salkovskis 1985, p. 576). Similarly, Jane might experience images of her house burning down because of an improperly flipped switch, along with NATs that appraise these images as representing significant threats. These NATs *about* the intrusive thoughts then produce anxiety and the motivation to counteract the threat, e.g., by seeking uncontaminated cosmetics, re-flipping switches, and so on. According to Salkovskis, these NATs arise from a more stable, general “inflated responsibility” belief according to which one has an unrealistic sense of power—and thus responsibility—to prevent disasters.

Nowadays, Salkovskis’s NATs are generally called “appraisals.” Aside from that terminological change, his model dominates recent psychological research on OCD, much of which has focused on the claim that appraisals arise from more general beliefs like the “inflated responsibility” belief that Salkovskis posited. Other researchers have suggested other beliefs that might generate OCD-related appraisals. For example, “thought-action fusion” (TAF) is the belief that thinking about a bad thing happening means that it is more likely to actually happen or that having an urge to do something bad is morally equivalent to doing it. Others are perhaps better characterized as belief-forming dispositions, such as the disposition to over-estimate the likelihood and badness of threats, and the tendency to find imperfection intolerable (Taylor et al. 2012).

In the psychological literature on OCD, these more general beliefs in things like inflated responsibility and TAF, which are thought to produce faulty appraisals, are usually referred to *as ‘beliefs.’* Interestingly, however, the word “belief” is *not* commonly used to refer to the appraisals themselves.[[3]](#endnote-3) This raises the question: What kind of mental state are these appraisals?

**3.1.** It might seem obvious that appraisals are beliefs. After all, they *act* like beliefs. If a person with an intrusive thought about something bad happening becomes fearful and motivated to take preventative action, it is natural to suppose that the cause is a *belief* that the bad thing might really happen unless preventative action is taken. Thus, we might suppose that the appraisals causing OCD symptoms are more or less normal beliefs with irrational contents. On the other hand, we *might* suppose that appraisals are more exotic entities. We might suppose that they are not beliefs—or at least not normal beliefs—at all. That is the suggestion I will defend here.

First, though, a few words about belief. Beliefs hold content that purports to represent the way that the world actually is (rather than how one wants it to be). They also allow this information to be put to use, as when my belief that there is beer in the refrigerator interacts with my desire to drink some beer to cause my refrigerator-approaching behavior. Beliefs may also produce emotion, which may in turn produce or enhance motivation, as when my belief that a bear lurks nearby produces fear and an enhanced desire to scram. The interactions I have in mind here are automatic—they don’t require explicit, conscious reasoning—and they are central to a belief’s core function of storing and exploiting information. They are, I contend, the minimal conditions for any mental state to be a belief or even to be belief-like.

However, the typical beliefs of psychologically normal adult humans—“functionally normal beliefs,” as I shall call them—have additional functional properties beyond this bare minimum. Two such properties are relevant for the topic at hand.

The first property, which I’ll call *affirmation,* characterizes an agent’s relationship to the contents of her functionally normal beliefs. It includes two main components: First, an agent with a functionally normal belief that P will be disposed to assert P, at least to herself, at least insofar as she is attending to the question of whether P is true. Second, an agent with a functionally normal belief that P will be disposed to use P as a premise in her *conscious* theoretical and practical reasoning, at least insofar as she consciously attends to this belief.[[4]](#endnote-4) Moreover, this disposition is not bound to any particular context. That is, an agent with a functionally normal belief that P will be disposed to employ P as a premise in any context in which she takes the truth or falsity of P to be relevant to her reasoning.[[5]](#endnote-5)

The second property I’ll call *evidential responsiveness*. A complete and precise account of this property is beyond the scope of this paper, but the following approximation should suffice: If an agent has a functionally normal belief that P, then, absent any strong attachment to P being true, if she becomes simultaneously aware of her belief in P and strong, obvious, and direct evidence that P is false, then her belief will typically disappear. This does not set a high bar, nor is it meant to: Functionally normal beliefs can be quite irrational, after all. However, a person who sincerely purports to believe something—at least when it is not a cornerstone of her world-view or central to her self-esteem—despite clear, obvious, and direct evidence that it is false, is often said to have a delusion rather than a functionally normal belief.[[6]](#endnote-6) Indeed, some philosophers have suggested that extreme delusions may not be beliefs at all. If Fred claims (sincerely and non-figuratively) that he, Fred, is dead (the Cotard delusion), one might wonder whether it is proper to say that Fred really *believes* that he is dead.[[7]](#endnote-7)

Similar questions arise with gross failures of affirmation. Suppose that, every time he sees a wiener-dog, Oscar experiences anxiety and the motivation to flee. Yet he sincerely reports that wiener-dogs are harmless, and he refuses to use the proposition that wiener-dogs are dangerous in his theoretical or practical reasoning. Although we might readily attribute a phobia to Oscar, we might be at a loss to know what *belief* to attribute to him.

It will be helpful to have a name for mental states which are belief-*like* in having propositional content and driving emotion and behavior in ways that would be rational if that content were true, but which differ from functionally normal beliefs because they are lacking or severely deficient in the properties of affirmation and evidential responsiveness. I shall dub them “quasi-beliefs.” Although I want to distinguish quasi-beliefs from functionally normal beliefs, I am equally happy thinking of quasi-beliefs as a (functionally *abnormal*) kind of belief, or as a mental entity which is not itself a belief but which is a member of the same genus as beliefs.

**3.2.** I propose that the appraisals driving high-insight cases of OCD are best understood as quasi-beliefs with contents that conflict with the contents of the agent’s functionally normal beliefs. Thus, we can explain Jane’s OCD by taking her anxiety and compulsive motivation to be driven by a *quasi-belief* that improperly-flipped switches pose a significant fire hazard—a quasi-belief that conflicts with Jane’s functionally normal belief to the contrary. Because this quasi-belief lacks the affirmation property, Jane does not assent to its content; nor does her explicit disavowal of the content require us to attribute contradictory *beliefs* to her. For the same reason, she does not use its content in her practical or theoretical reasoning—hence her lack of attempts to warn her friends or sue her home’s builder.[[8]](#endnote-8) Similarly, if we attribute to Raymond a quasi-belief that buckets of plague are commonly left lying about—a proposition that conflicts with his functionally normal belief to the contrary—we can explain both his anxiety and compulsive motivation as being driven by the quasi-belief. But we can also explain why he asserts that this proposition is false, and why he forgoes using it in his theoretical or practical reasoning. Finally, attributing to J.F. a quasi-belief to the effect that sunlight can turn cosmetics into carcinogens explains why she is anxious and avoidant of such cosmetics, even though she asserts that this idea is far-fetched, and even though she does not employ it as a premise in her practical or theoretical reasoning.

The claim that appraisals are quasi-beliefs also accounts for the *persistence* of OCD symptoms. Consider checking compulsions. According to the cognitive model, they arise when a person has an intrusive thought about, say, burglars entering an unlocked door. She appraises this intrusive thought as indicating a significant possibility, which causes anxiety and a motivation to check. Now this explains why she is motivated to check—once. But persons with OCD often check the very same thing dozens of times—even though each check provides what should be sufficient evidence to banish any *belief* that the doors are still unlocked.

Similarly, a person with washing compulsions continues to experience anxiety about contamination despite strong evidence—provided by the fact that he has just scrubbed, disinfected, bleached, etc.—that no contamination is present. More bizarre fears and compulsions also display this resistance to evidence. Raymond must have ample evidence that buckets of plague are not commonly left lying about. J.F. (who attended medical school) no doubt has access to plenty of evidence that sunlight does not transform common cosmetics into carcinogens. If appraisals are quasi-beliefs, which are by definition unresponsive to evidence, then these facts about OCD are no longer puzzling; instead, they are exactly what we should expect.

**4.1.** The argument offered here is one of a growing family of arguments designed to show that certain mental phenomena can be best explained by the existence of mental states that are belief-like, but which lack key features of functionally normal beliefs. Many of these arguments posit mental states that resemble the quasi-beliefs introduced here. For example, Stephen Stich (1978) has posited “sub-doxastic states” as the bearers of informationally encapsulated information used in sub-personal mental processes like vision and grammar parsing. William Tolhurst (1998) described “seemings” as propositional attitudes which share some but not all of the features of beliefs, and which are often the forerunners of belief. Andy Egan (2008) suggests that “bimagining”—a hybrid between imagining and belief—can explain certain otherwise puzzling delusions. Robert Noggle (1995) posited a kind of quasi-belief to explain how conditioning and habit-learning can produce actions with respect to which the agent is not fully autonomous.

Some theorists of emotion have proposed states akin to quasi-beliefs to explain the phenomenon of “recalcitrant emotion.” An appealing idea is that emotions are typically connected with or partly constituted by judgments or beliefs. For example, a person who experiences a fear of falling normally believes that falling is currently a threat. However, a person can experience a “recalcitrant” fear of falling without holding such a belief, for example, if she knows that she is safely behind a solid railing looking down from a great height. One common approach to recalcitrant emotion—sometimes called “quasi-judgmentalism”—ties emotion to a mental state that is similar to, but not quite the same as, a belief. Such states are typically said to share belief’s mind-to-world direction of fit and its causal power to generate affect. Because it is not a full-fledged belief, its content can conflict with what the agent really does believe, so that an agent may believe that falling is *not* a significant threat, while having a fear-inducing belief-like state with the content that falling *is* a significant threat. Such belief-like states include the “construals” introduced by Robert Roberts (2003, esp. 89-93), the “evaluative thoughts” or “propositional feelings without assent” proposed by Patricia Greenspan (1988, esp. 13-20; 45), and the “distinctively emotional assent” which “falls sort of judging or believing” proposed by Bennett Helm (2007, esp. 36-46; 64-70). These proposed mental states share much with the quasi-beliefs proposed here: They are all states which have propositional content, a mind-to-world direction of fit, and the ability to create affect. Yet they fall short of being functionally normal beliefs, and their propositional contents can conflict with those of the agent’s functionally normal beliefs.[[9]](#endnote-9)

Probably the most extensive account of a mental state similar to the quasi-beliefs proposed here appears in Keith Frankish’s book *Mind and Supermind*. Frankish argues that folk psychology contains two very different conceptions of belief. “Basic beliefs” are packages of behavioral dispositions to act in ways that would be advantageous if a given proposition were true. They are non-linguistic and non-conscious, and are present in both adult humans and in non-linguistic creatures. By contrast, “superbeliefs,” which supervene on basic beliefs, are policies of using some (often linguistically formulated) proposition as a premise available to conscious reasoning in any relevant context. Frankish’s superbeliefs resemble what I am calling functionally normal beliefs in that both are available for use in conscious reasoning that is not restricted to any particular context. Moreover, both are available to introspection and are apt to be affirmed verbally by the agent. “Basic beliefs,” like quasi-beliefs, lack these properties. Moreover, Frankish allows that basic beliefs may conflict with superbeliefs, and proposes that such conflicts might explain otherwise puzzling mental phenomena such as akrasia and delusions (Frankish 2004, 2012).

Despite these parallels, I am not ready to sign on to all of Frankish’s claims: First, Frankish argues that the basic/superbelief distinction corresponds with various other distinctions, including the distinction between partial and flat-out belief, the distinction between austere and rich functionalism, and the distinction between standing and occurrent beliefs. This is a bold and intriguing claim—about which I prefer to remain agnostic for now. Second, Frankish maintains that superbeliefs supervene on basic beliefs (and basic desires, which are the conative counterparts of basic beliefs). Consequently, for Frankish, superbeliefs and superdesires (the conative counterpart of superbeliefs) do not cause action directly; rather, they produce action because they supervene on basic beliefs *about* premising policies and basic desires to follow those policies, which have direct access to the machinery of action. I am skeptical about this picture, since it requires basic beliefs and desires—which we are encouraged to see as fairly unsophisticated states—to have such abstractions as a “policy of using P as a premise” in their contents. Third, Frankish maintains that the basic/superbelief distinction is separate from the distinction between beliefs and “sub-personal” doxastic state (like the kind that Stich introduces). I prefer to remain open to the possibility that quasi-belief may be a sub-personal state. Despite these quibbles, however, much in Frankish’s work is congenial to the proposal on offer here.

In sum, a number of recent lines of philosophical argument support the claim that a fully worked out philosophical psychology must include mental states that are belief-like but which are lacking or severely deficient in the properties of affirmation and evidential responsiveness. These other lines of argument both support and are supported by the analysis of OCD offered here: To the extent that these other lines of argument are convincing, they make it more plausible to see OCD as merely one more phenomenon whose explanation requires belief-like states. And to the extent that the current analysis is convincing, it adds to the cumulative case for the existence of such states.

4.2. However, some analyses of mismatches between behavior and professed belief do not introduce mental states like quasi-beliefs. Such analyses provide potential alternatives to the quasi-belief analysis of OCD.

Tamar Szabo Gendler argues that “aliefs” best explain certain belief-behavior mismatches that are structurally similar to those that appear in OCD. One of her main examples involves recalcitrant emotion: A person encountering a glass-bottomed skywalk high above the Grand Canyon is fearful of walking on it—perhaps to the point of being unable to do so—despite knowing that it is safe. A second example involves a person who reflexively reaches for her wallet to pay for something, despite knowing that she left the wallet at home.

According to Gendler, such cases are best explained by “aliefs.” An alief is “a mental state with associatively linked content that is representational, affective and behavioral, and that is activated—consciously or nonconsciously—by features of the subject's internal or ambient environment” (Gendler 2008, p. 642). Although Gendler toys with the idea that aliefs might have propositional content (2008, p. 644), her considered view is that they do not: “Believing and supposing and imagining and pretending are all (at least on certain uses of the expressions in question) propositional attitudes, whereas alieving (as I am provisionally using the expression) is not” (Gendler 2008, p. 647f.). But although aliefs do not assert propositions, they do have content (2008, p. 650). They represent a situation or object, and they link it associatively to affect or a motor routine. Thus, in the skywalk case, the alief links a representation of height to fear; in the wallet case, alief links a representation of a wallet-requiring situation to motor routines involved in reaching for one's wallet.

Although a non-propositional alief may suffice to explain the phenomena Gendler seeks to explain, I contend that positing a state with propositional content is necessary to explain the complexity of OCD.

First, the anxiety in OCD is more complex than the raw affect that Gendler sees at one end of the associative chain that comprises an alief. The person who hesitates to walk onto the glass-bottomed skywalk is afraid *of* falling, and avoids the skywalk in the same reflexive way that everyone tends to avoid something scary. Jane, to be sure, is afraid *of* her house burning down. But there’s more to her anxiety than this. She is also afraid *that her house might burn down because she failed to ensure that her switches were properly flipped*. The content of the anxiety in OCD is not just an object, but a proposition—and a rather complex one at that.

Second, the compulsive behaviors motivated by this *anxiety that P* are more complex than simple avoidance behavior (as in Gendler’s skywalk case) or stereotyped motor routines (as in Gendler’s wallet case). Since compulsive behavior is repeated, it would be strange not to find some of it becoming habitual after a while. But much of the compulsive behavior in OCD is far more sophisticated than mere avoidance or habitual motor routines. Consequently, it calls out for an explanation in terms of a propositional attitude. Jane’s checking is not a reflex or simple avoidance response; it is a deliberate attempt to satisfy a desire to ensure that the switch is properly flipped. Jane deliberately chooses how to satisfy this desire: She may check it herself, she may ask someone else to do so. A person with cleaning compulsions does not simply display a simple motor routine like checking for one’s wallet. Rather, she responds deliberately to a desire to remove contamination. Thus, she will typically decide how to clean, what cleaners to use, what to clean first, and so on. In short, compulsive behavior is more than just the reflexive triggering of motor routines involving checking, washing, etc. It is a deliberate response to a desire to prevent a dangerous state of affairs from obtaining. Such a desire is a propositional attitude, and it is most naturally explained by other propositional attitudes, including a desire to avoid danger and an attitude that asserts that a certain action is an effective means of preventing danger. Normally, this second attitude would be a belief; in OCD, I contend, it is a quasi-belief. What is crucial, though, is that it is an attitude with propositional content.

There is a more general point to be made here. One might worry (as did an anonymous reviewer) that the proper conclusion to draw from the problems with the claim that appraisals are beliefs is simply that they are not propositional attitudes at all. Here again, though, it is important to emphasize that OCD involves not just some raw anxiety; it is anxiety that some dreaded state of affairs might come true, along with motivation to take suitable precautions. Moreover, the compulsive motivations typically bear a clear relationship to the content of the obsession. Persons with contamination obsessions experience motivation to wash. Persons with obsessive thoughts about disasters occurring because of unlocked doors or improperly flipped switches tend to check them. These motivations are exactly what we would expect if they believed a certain proposition, namely that the content of the intrusive thought is a realistic possibility that must be countered. It is difficult to see how any analysis of OCD can make proper sense of why the anxiety motivates very specific sorts of behavior (as opposed to simple avoidance behavior motivated simply by the aversiveness of the anxiety itself) unless it posits some sort of propositional attitude that asserts that a disaster is likely unless appropriate action is taken.

Another potential alternative analysis of OCD derives from the work of Eric Schwitzgebel. Schwitzgebel argues that belief-behavior mismatches are best explained by adopting a dispositionalist account of belief, according to which to believe that P is simply to have a package of dispositions to say and do various things that it would be sensible if P were true (Schwitzgebel 2001). However, Schwitzgebel holds that “’believes that P’ is a vague predicate,” because there can be cases of only “partial match in functional role: Some but not all aspects of the relevant functional role may be satisfied” (Schwitzgebel 2010, p. 536). According to Schwitzgebel, this explains belief-behavior mismatches: A person has some but not all of the dispositions stereotypical to two contradictory beliefs. In such cases, a person does not determinately believe P or its denial. Rather, she is in a state of “in-between belief.”

Although Schwitzgebel does not explicitly address OCD, one might wonder whether his view provides a plausible alternative to the quasi-belief model. Thus, we might claim that Jane is an in-between belief state with regard both to the claim that improperly flipped light switches pose a fire hazard, and the claim that they do not. On Schwitzgebel’s view, her case only appears puzzling because it is an example of the vagueness of belief, which is a consequence of his dispositionalist view of belief. Jane has certain dispositions—such as those involved in the generation of affect and immediate motivation—that are characteristic of believing that light switches pose a fire hazard. And she has other dispositions—such as those involving employing a proposition in conscious reasoning—that are characteristic of believing that light switches do not pose a fire hazard. She is in a state of in-between belief with regard to both propositions.

My main reason for not adopting an in-between belief account of describing OCD is simply that, for reasons that are neither original nor within the scope of this paper, I am not drawn to the dispositionalist account of belief on which it is based. Nevertheless, I concede that a dispositionalist analysis can capture *most* of what we should say about OCD. To do this, we must be careful to point out that someone like Jane is in a state of in-between belief with regard to two separate propositions. Moreover, her conflicting states of in-between belief display different subsets of the package of dispositions that normally characterize belief. To avoid losing this crucial information, a dispositionalist would need to specify which dispositions go with which in-between belief states (Schwitzgebel 2001, 82).

Nevertheless, I suspect that the in-between belief account will have trouble accounting for an important asymmetry between the two mental states held by someone like Jane. The asymmetry involves what we might call “agential authority.” Jane’s functionally normal belief has a more solid claim on being the authentic voice of Jane herself than does the quasi-belief. Although both the belief and the quasi-belief are assertions, only the former counts as what Jane herself asserts. The fact that the quasi-belief account sees quasi-belief as a degenerate form of belief mirrors our sense that Jane is beset by something that is alienated from her authentic self. Although this may seem like a somewhat ethereal notion, it plays a key role in therapy: A clinician does not treat the conflict between Jane’s mental states by getting her to give up her stubborn insistence that light-switches are safe. The fact that any reputable therapy for OCD privileges what I am calling functionally normal belief over what I am calling quasi-belief reflects this asymmetry in the relationships that the states have to Jane’s true self.

It is not clear that the dispositionalist account is well-poised to capture this asymmetry. The dispositionalist simply notes that each of the two mental states departs in certain ways from the total package of dispositions characteristic of belief. As far as I can see, it lacks a natural way of attaching one but not the other to the agent herself.

**5.1.** Proponents of the cognitive model of OCD might raise various objections to the claim that appraisals are quasi-beliefs. One arises from the fact that the cognitive model sees appraisals as deriving from more general beliefs (like TAF and inflated responsibility) in a way that suggests that they, too, are beliefs. The contents of these more general beliefs imply that intrusive thoughts pose or signal danger that must be counteracted. When an intrusive thought arises, these general beliefs give rise to an appraisal that this particular intrusive thought poses or signals a threat. But this is exactly how we would expect a *belief* that this intrusive thought poses or signals a threat to arise. Consequently, it seems reasonable to regard appraisals as specific, occurrent beliefs that instantiate more general standing beliefs about intrusions when a specific intrusion appears.

One problem with this challenge is that it rests on a feature of the cognitive model of OCD that has been subject to empirical critique. Although there appear to be correlations between OCD and holding beliefs like TAF and inflated responsibility, recent studies have found that a significant number—perhaps half—of persons with OCD do not appear to hold any of the general beliefs posited by the cognitive model as the source of OCD-related appraisals (Taylor et al., 2012; Calamari, Cohen, Rector, Szacun-Shimizu, Reimann, & Norberg, 2006; Julien, O’Connor, & Aardema 2007). Of course, these findings might simply mean that OCD has multiple causes, and that sometimes but not always the defective appraisals arise from these more general beliefs. In any event, these findings call into question the claim that OCD-related appraisals (always) derive from more general beliefs. Consequently, they undercut the objection that appraisals cannot (ever) be quasi-beliefs because they (always) arise in ways that suggest that they are functionally normal beliefs.

But even if appraisals do arise from beliefs in things like TAF and inflated responsibility, this would not settle the matter of whether appraisals are also ordinary beliefs. Although beliefs can certainly produce other beliefs, they can also produce other mental states, e.g., desires and emotions. In principle, there is no reason why a belief in TAF or inflated responsibility might not be able to produce quasi-beliefs as well.

**5.2.** A second, more serious challenge to the quasi-belief account of OCD arises from the fact that many therapists now treat OCD with cognitive therapy,” which uses evidence-based rational persuasion to convince patients of the falsity of the propositions that seem to drive their anxiety. If patients like Jane can be treated by exposure to evidence that, say, a fire will not *really* start if the lights are improperly switched, then OCD would seem to be driven by functionally normal beliefs with false or irrational contents, rather than *evidence-resistant* quasi-beliefs.

One might expect it to be straightforward to determine whether OCD can be treated effectively by exposing patients to evidence that the contents of their appraisals are false. But matters are far more complicated. There is considerable overlap between newer cognitive therapies and the older, behaviorist-inspired treatment modalities (Abramowitz, Taylor, & McKay 2005; Foa 2010). Some clinicians emphasize ERP understood in behaviorist terms (habituation and extinction), while adding cognitive interventions to improve insight and the resolution to tolerate the anxiety involved in ERP. More cognitively-oriented clinicians emphasize rational, evidence-based persuasion, but they also commonly employ a technique known as a “behavioral experiment.” This is similar to ERP, but it is described as an evidence-gathering exercise in which the patient tests the hypothesis that disaster will occur if the compulsion is not performed in response to the intrusive thought (Wilhelm & Steketee 2006; Abramowitz et al., 2005, pp. 141-142). Further complicating matters, many clinicians call their preferred treatment ERP, but describe its operation in cognitive, evidence-gathering terms. For example, Foa and colleagues (2012, p. 59) write that “The effects of exposure without ritual performance are conceptualized as a change in the patients’ beliefs once they have experiences that disconfirm the erroneous beliefs that are part of their OCD.”

So someone with a checking compulsion might be asked to leave the house without checking. Typically, he will experience a reduction in his initial anxiety after about an hour. The behaviorist model explains this in terms of habituation. But the cognitive alternative describes it as a behavioral experiment that provides *evidence* that *disconfirms* his *belief* that a failure to check invites disaster. Under the pressure of this evidence, the belief goes away, and with it the anxiety that it formerly generated. Similarly, a compulsive washer asked to touch various surfaces on a bus without washing could be described as undergoing ERP to habituate anxiety and extinguish compulsion. Or she could be described as conducting a behavioral experiment to test the hypothesis that public spaces are so contaminated as to pose a serious health threat (Challacombe, Oldfield, & Salkovskis 2011, pp. 184ff).

The fact that most forms of psychological treatment for OCD use similar techniques under different descriptions—some cognitive and some behavioral—vastly complicates attempts to determine whether OCD can be treated effectively simply by exposing patients to evidence that disconfirms irrational but functionally normal beliefs. Moreover, most treatment studies have compared ERP to forms of cognitive therapy *which include* behavioral experiments. Although the results are mixed, taken as a whole, such studies have yet to provide clear, consistent evidence for the effectiveness of cognitive interventions that do not include either ERP or behavioral experiments. Nor is there much evidence that the therapeutic approaches that combine cognitive interventions with ERP or behavioral experiments are significantly more effective than “plain old” ERP (Ponniah, Magiati, & Hollon 2013; Abramowiz et al. 2005; Daflos & Whittal 2012; Foa 2010; and Taylor et al. 2012.). In short, there is little evidence for the effectiveness of purely and unequivocally cognitive interventions either as alternatives or additions to ERP or its alter ego, behavioral experiments. This undercuts the claim that appraisals cannot be evidence-resistant quasi-beliefs because they can be eradicated by exposing them to evidence.

**5.3.** The response to the previous challenge might be fairly decisive except for one thing: As we just noted, ERP itself can be re-described as an evidence-gathering “behavioral experiment.” Thus, one could argue that the effectiveness of ERP—in and of itself—supports the claim that appraisals are functionally normal *beliefs* (which respond to evidence) rather than quasi-beliefs (which by definition do not). If ERP is best understood as a process by which patients are exposed to evidence that disconfirms their appraisals, then even if other cognitive interventions are relatively ineffective for treating OCD, the claim that appraisals are evidence-resistant quasi-beliefs would still be in trouble. The efficacy of other, unequivocally cognitive interventions would be beside the point if ERP works by exposing appraisals to evidence.

However, there are problems for this evidence-gathering interpretation of ERP. One involves the time-scale on which ERP operates. Recall that during ERP the anxiety normally dissipates within 1-2 hours, and remains lower after the session. This timeframe often fails to match the timeframe required to disconfirm the content of the appraisals.

For example, a study of persons with washing compulsions found that 60 minutes of ERP decreased anxiety and washing urges in a group of patients whose OCD was driven by thoughts about illness. This finding is not plausibly described as gathering evidence to disprove a hypothesis about a threat. As the authors note, “These findings seems counterintuitive given that . . . individuals with illness-related primary threats . . . did not appear to receive immediate disconfirmation for this threat, since signs of illness would presumably not appear until later” (Cougle, Wolitzky-Taylor, Lee, & Telch, 2007, p. 1457). If ERP works by *disconfirming* the *hypothesis* that failing to wash will cause disease, then it should take far longer than 60 minutes to work, since diseases take much longer than an hour to manifest.

Similarly, an authoritative handbook for ERP suggests instructing persons with checking compulsions to pay their monthly bills by writing checks without checking them for accuracy (Foa et al. 2012, p. 96). Therapists are instructed to record the patient’s anxiety levels during the rest of the *two-hour therapy session*. Presumably the anxiety decreases during that time, as is normal in ERP.[[10]](#endnote-10) But of course this isn’t nearly enough time to disconfirm the fears that one might have about making mistakes when paying one’s bills. Even the fastest repo man can’t take your stuff before the bad check goes out in the mail!

More generally, Gillihan and colleagues note that, as a result of ERP “patients sometimes report no longer believing that their feared consequence will happen even if the event is relatively far in the future and could not logically have been disconfirmed—for example, the fear that one will go to hell for blasphemy” (Gillihan, Williams, Malcoun, Yadin, & Foa 2012, p. 253). If a person fears that something bad will occur in the coming days, months, or years, and this fear dissipates because the bad thing did not happen within an hour or two, then “evidence-based disconfirmation” is not an apt way to describe what happened.

A second problem for the evidence-gathering reinterpretation of ERP is that it fails to make sense of the finding that the exposure portion of ERP is somewhat effective in treating OCD all by itself. In a classic study by Edna Foa and colleagues, subjects with washing compulsions “were exposed in vivo to their discomfort-evoking stimuli throughout each 2-hr therapy session. For homework they were instructed to further expose themselves daily to the same stimuli for an additional uninterrupted 4-hr period. . . . *Patients were allowed to wash or clean as they wished, but during these 6 hr of exposure they were instructed to recontaminate themselves immediately after washing. They could wash unrestrictedly for the remainder of the day*” (Foa, Steketee, Grayson, Turner, & Latimer 1984, p. 454, emphasis added). Patients undergoing this treatment improved less than patients who got both components of EPR. But they *did* improve: They became significantly less anxious about being exposed to contaminants, and somewhat less motivated to wash in response.

This finding poses a problem for the cognitive interpretation of ERP. The propositional content of the appraisal is presumably something like “failing to wash will result in illness.” But this proposition was *not* disconfirmed by the procedure: If I believe that *failing* to wash will result in illness, then the fact that I have not become ill after I *have* washed does nothing to disprove that belief. If ERP is evidence-gathering disconfirmation, then exposure alone should not have the therapeutic effect that Foa and her colleagues found it to have.

A third finding that makes it difficult to portray ERP as a process that changes beliefs by exposing them to evidence is that “multiple studies have found that exposure works better when patients focus their attention on the feared stimulus rather than distracting themselves during exposure” (Gillihan et al. 2012, p. 253). By comparison, consider this very boring experiment: Recently I installed a new garbage disposal and was concerned about possible leaks in the drain. So I left a bucket under the parts I had replaced. Days later, I found the bucket empty, and ceased to worry about leaks. Notice that I did not need to constantly attend to the pipes and “face my fear” to discover that they were not leaky. If ERP were simply a matter of experimenting to find out that a feared outcome will not come to pass, then seeing the results should suffice, and it should make no difference whether the patient pays attention *during* the experiment. The fact that it *does* make a difference poses a problem for the evidence-gathering interpretation of ERP.

A fourth finding that poses a problem for the evidence-gathering interpretation of ERP is that a technique called “imaginal exposure” is fairly effective in treating OCD. This technique, often described as a variant of EPR, involves the patient simply *imagining* that the feared outcome happens because she fails to perform the compulsive action (Foa et al. 2012, pp. 53-58). For example, a person with obsessive thoughts of stabbing his grandchildren might be instructed to vividly imagine doing just that (Rowa et al. 2007, p. 94-95), or a person with contamination obsessions might be instructed to imagine contracting a disease because she did not wash sufficiently after using a public restroom (Foa 2010, p. 201). As with “in vivo” ERP, imaginal exposure is often portrayed as an evidence-gathering operation: Foa and colleagues recommend telling patients that “imaginal exposure will teach you that having horrible thoughts or images does not make them come true” (Foa et al., 2012, p. 104). Yet they also note that this type of exposure is ideal for “long-term future consequences that cannot be detected immediately, such as “brain damage in 30 years” or “going to hell” (Foa et al. 2010, p. 105).

Treatment studies indicate that imaginal exposure works fairly well, though not quite as well as “in vivo” ERP. But this is extremely difficult to explain in evidence-gathering terms. Imagining a bad thing happening because I failed to perform the compulsive action does nothing to disconfirm my belief that failing to perform that action will cause the bad thing to happen. Nor is it plausible to see imaginal exposure as disconfirming the belief that just thinking about a bad thing happening will make it more likely to happen. For as we have just seen, imaginal exposure is explicitly recommended for worries about disasters that would occur far in the future. The proposition that having intrusive blasphemous images will doom me to eternal damnation cannot be disconfirmed just by the fact that I am not roasting in Hell a few hours after provoking such images.

In short, ERP does not seem to operate by providing evidence to disconfirm beliefs. Since there is little evidence for the efficacy of cognitive therapies that lack ERP or something like it, and since ERP cannot be plausibly construed as an evidence-gathering process, there is little evidence that appraisals are susceptible to evidence in the way necessary to disprove the quasi-belief model of OCD.

**6.** In sum, the challenges seem insufficient to defeat the prima facie case for the claim that OCD, especially in persons with good insight, is *often* driven by quasi-beliefs rather than functionally normal beliefs. However, there are good reasons to stop short of the stronger claim that OCD is *always* driven by quasi-beliefs. First, it would be an overreach at this point to claim that functionally normal beliefs *never* produce OCD. Second, OCD is a very heterogeneous condition which may have multiple causes, so that in some cases it may be caused by quasi-beliefs, and in others it may be caused by irrational but functionally normal beliefs. Third, some forms of OCD do not lend themselves particularly well to either the belief or quasi-belief model, since it is not clear that they involve appraisals at all. For example, some persons with OCD experience compulsions to count, order, or achieve symmetry. In such cases, the patient may not report fearing any particular outcome if these actions are not undertaken. Consequently, it is not clear that such cases are best described as involving anything like a belief or a quasi-belief.[[11]](#endnote-11)Still, the claim that quasi-beliefs are the best explanation for at least some cases of OCD is a significant thesis. First, it provides what I think is an especially good argument for the existence of belief-like mental states that are not functionally normal beliefs. Thus, it provides at least some indirect support for other proposals (like those discussed in section 4) that seek to introduce similar mental states to explain other otherwise puzzling mental phenomena.

Second, the quasi-belief analysis suggests a way to think about the relationship between OCD and autonomy. Space permits only a brief sketch, but the basic idea is simple enough.[[12]](#endnote-12) The quasi-belief analysis sees the essential problem in OCD as an internal conflict between a mental state that asserts P, and one that asserts not-P. But OCD is not a matter of *the agent* asserting a contradiction. Rather, it is a matter of the agent asserting something while her behavior and emotion are driven by a mental state that asserts something else. As I suggested in my discussion of Schwitzgebel, the belief represents the authentic voice of the agent. The quasi-belief, by contrast, is alienated from the agent inasmuch as it asserts something that the agent herself (via her functionally normal belief) denies. Yet this very mental state, from which the agent is alienated, causes her to have feelings and motivations that are themselves alien to her, for they are based on a proposition that she (authentically) believes to be false. Hence, on the quasi-belief view, OCD implies not simply a lack of control by the agent over her behavior (a theme explored by Meynen 2012). It is also a situation in which something *else*—something alien to her authentic self because it asserts a proposition that she denies—threatens to wrest control from her. Since quasi-beliefs and the compulsive motivation they produce persist even when confronted with the agent’s beliefs (and the evidence for them), over time, they are likely to wear down her ability to resist, so that even though she knows that they are senseless, she is likely to act on them anyway.[[13]](#endnote-13)

**Acknowledgement:**

I thank several anonymous reviewers and audiences at the 2014 Western Michigan Medical Humanities Conference and the 2014 Northwest Philosophy Conference for helpful suggestions.

**NOTES**

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1. Although the reports do not explicitly state that the subjects did not undertake such actions, it seems likely that such actions would be mentioned if they had occurred. [↑](#endnote-ref-1)
2. There are interesting connections between OCD and both religious rituals and evolutionarily old grooming and vigilance behaviors (see, e.g., Rappoport and Fiske 1998). In OCD, however, these behaviors are undertaken to maladaptive extremes, and/or in amounts or manners that would be seen as excessive or irrational from the point of view of the agent’s culture or religious community. Hence, OCD may represent a malfunction in brain mechanisms that subserve adaptive grooming and attentiveness to danger, and culturally meaningful religious rituals. Even if this is correct, it does not resolve the puzzle of what beliefs to attribute to a person who is acting in ways that she herself finds to be irrational, extreme, or excessive. [↑](#endnote-ref-2)
3. One exception may be Brakoulias and Starcevic 2011, who use “belief” to refer to mental states that arguably play the same role in generating OCD symptoms that other researchers attribute to appraisals. Interestingly, though, they attribute to these beliefs many of the very properties that I will later argue make them unlike ordinary, “functionally normal” beliefs. [↑](#endnote-ref-3)
4. The first element is sometimes called “assent.” The second is often called “acceptance.” [↑](#endnote-ref-4)
5. In the terminology of Frankish 2004 (130-132), I take belief to include “unrestricted acceptance.” [↑](#endnote-ref-5)
6. The evidence-resistance of beliefs in which the believer is personally invested is sometimes taken as reason to reject an evidential responsiveness requirement for belief. However, the kinds of propositions relevant to OCD—such as the door being unlocked or the doorknob being contaminated with HIV—are not ones we would expect a person to be emotionally or epistemically invested in. Hence, an evidential responsiveness condition is more plausible for beliefs about the kinds of propositions relevant to OCD than it might for beliefs central to the person’s world-view, self-esteem, etc. [↑](#endnote-ref-6)
7. Bortolotti 2010 provides a definitive survey of such arguments, though she comes out against the idea that delusions are anything other than beliefs. [↑](#endnote-ref-7)
8. Or, if she does use it in reasoning, she only does so in a very restricted context. An anonymous reviewer suggests that we might describe Jane as reasoning from the proposition that the switch might start a fire if improperly switched to the conclusion that she ought to make sure that it is properly switched, which then produces a desire to act. My inclination is to see this not as the result of conscious reasoning, but as an automatic generation of the desire to act from the quasi-belief. Since I see no clear way to decide which description is correct, I rely on the qualification that functionally normal beliefs are *not* domain-restricted to address the possibility that Jane might be using the quasi-believed proposition in a very domain-restricted form of reasoning that generates her compulsive motivation. [↑](#endnote-ref-8)
9. An anonymous reviewer suggests that we might explain OCD in much the same way that quasi-judgmentalism explains recalcitrant emotion. I agree that the anxiety in OCD counts as a recalcitrant emotion, and I am inclined to give a quasi-belief analysis of phobias. However, there are important differences between recalcitrant fear (phobias) and OCD. OCD is a compound of recalcitrant anxiety *and* “recalcitrant” motivation. Moreover, this motivation is more complex than the simple avoidance behavior found in phobias (more on this below)—so much so that it is not plausible to regard compulsive motivation in OCD as generated entirely by recalcitrant anxiety. Rather, it seems best explained by reference to the same quasi-belief that causes the anxiety. So while the account of OCD developed here is compatible with quasi-judgmentalism about emotions, it is more congenial to versions of that view that see recalcitrant emotion as being caused by a quasi-belief that is *separate* from the emotion than to versions that see the quasi-belief as a component of the emotion, since in OCD, the quasi-belief appears to have an effect on motivation that is independent of its effect on anxiety. [↑](#endnote-ref-9)
10. The authors don’t report outcome data on this exercise, but presumably they would not have included it unless it had proven effective. [↑](#endnote-ref-10)
11. See, e.g., Brakoulias and Starcevic 2011. Although such forms of OCD are awkwardly handled by both the belief and quasi-belief models, the latter’s handling of them is arguably less awkward: Perhaps in such cases a quasi-belief that disaster will happen if I don’t count the ceiling tiles generates the compulsion to count without generating a conscious fear or feeling that disaster will strike if the counting is not done. [↑](#endnote-ref-11)
12. This account draws from Noggle 1995. [↑](#endnote-ref-12)
13. On the notion that a persistent desire may become compulsive by “wearing down” the ability to resist, see Zaragosa 2006 and Levy 2007, pp. 197-219. [↑](#endnote-ref-13)