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The Moral Psychology of Obsessive-Compulsive Disorder

A Dissertation submitted in partial satisfaction
of the degree requirements for

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in

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by

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The origin of this dissertation, the Moral Psychology of OCD, is not difficult for me to trace when I reflect on my time at UCR. In my first seminar on human agency, I wrote a term paper about the role of bizarre beliefs and bizarre ends and their relation to intentional agency. The example I drew from was that of folks with OCD who are delusional or lack significant insight into their condition. Since that seminar, I have frequently incorporated the perspectives of those with psychopathology, especially OCD, in my coursework as it became more and more of a focus for my research. Later on, the germ of my dissertation began with a critique of a single footnote about identification in OCD. That analysis has now expanded to four chapters covering everything from epistemic injustice in representation of OCD, the role of reason-responsiveness in the disorder and its broader philosophical implications, how to understand identification in cases of low-insight OCD, and the nature of the epistemic attitudes at work in the maintenance and etiology of the disorder. At every turn of this path, Agnieszka has remained a superlative mentor, scholar, and teacher.

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ABSTRACT OF THE DISSERTATION

The Moral Psychology of Obsessive-Compulsive Disorder

by

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The literature on philosophy of agency often appeals to atypical cases of agency, particularly addiction, psychopathy, compulsion, and psychosis. These appeals are sometimes distorted in ways that obscure both the disorders themselves and any more general insights about human agency that might be gained from analyzing them. While some of these distortions are documented and discussed in the literature (as is the case with psychopathy), little has been done to address philosophical mischaracterizations of obsessive-compulsive disorder (OCD). Here I provide the beginnings of a moral psychology of OCD, tracing ways in which it challenges a variety of held assumptions in the agency literature and charting a path toward an illuminating and univocal philosophical account of OCD.

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The Moral Psychology of Obsessive-Compulsive Disorder

> Often she found herself sitting and looking, sitting and looking, with her work in her hands until she became the thing she looked at – that light, for example. And it would lift up on it some little phrase or other which had been lying in her mind like that – 'Children, don't forget, children don't forget' – which she would repeat and begin adding to it, It will end, it will end, she said. It will come, it will come, when suddenly she added, We are in the hands of the Lord.
>
> But instantly she was annoyed with herself for saying that. Who had said it? Not she; she had been trapped into saying something she did not mean. She looked up over her knitting and met the third stroke and it seemed to her like her own eyes meeting her own eyes, searching as she alone could search into her mind and her heart, purifying out of existence that lie, any lie. […]
>
> What brought her to say that: 'We are in the hands of the Lord?' she wondered. The insincerity slipping in among the truths roused her, annoyed her.
>
> Virginia Woolf, *To the Lighthouse*[1]

When we evaluate our own attitudes, or the attitudes of others, it matters quite a bit to us whether such attitudes are genuinely representative of ourselves or others. Intrapersonally it is desirable to be a unified agent, who is seldom alienated from the thoughts, attitudes, and actions that occur within her. In the passage above from *To the Lighthouse*, Mrs. Ramsay becomes frustrated with a thought (that 'we are in the hands of the Lord,') from which she feels alienated. She thinks it cannot possibly be *her own* since she believes no such thing. Interpersonally, we want to know what attitudes, behaviors, or expressions speak for a person, else our evaluations of her may be ill-founded. Mrs. Ramsay would likely loathe the thought of someone associating her with the idea that we

[1] Woolf, "To the Lighthouse," 225-226.

are all in the hands of the Lord. Mrs. Ramsay's experience, one example on the spectrum of similar experiences many of us have throughout our lives, speaks to the importance we place upon what agency theorists term *internality*.

In the literature on philosophy of agency, there are two senses of internality that are invoked (or elided). Mrs. Ramsay's experience of an alien thought relates to internality in the *weak* sense, which invokes authorship. Mrs. Ramsay is startled by the appearance of a thought within her mind that she did not herself conjure up - making it external to her despite occurring within her mind. Compare this to the *strong* sense of some attitude being internal, which involves either explicit, wholehearted endorsement of the attitude or that the attitude is "inextricably part of the subjective lens through which you currently interpret the world," as Agnieszka Jaworska describes it.[2] One literal example of wholehearted endorsement is when Martin Luther, declaring of his theses rejecting the papacy, wrote "I cannot and I will not recant anything, for to go against conscience is neither right nor safe. Here I stand."[3] Although aspects of the quote may be apocryphal, Luther is declaring that his statements are reflective of his true viewpoint (and not merely statements he had authored in a moment of weakness). On this distinction, weak internality can characterize weak-willed actions - those choices that we author but do not stand behind, whereas strong internality can characterize only those

[2] Jaworska, "Identificationist Views" 21. See also Fischer, "Responsibility and Autonomy: The Problem of Mission Creep," 173-9.
[3] https://www.nationalgeographic.com/news/2017/10/martin-luther-freedom-protestant-reformation-500/
This quotation is attributed to Martin Luther circa 1521 at the Diet of the Worms.

choices that are deeply, and representatively, ours.[4] Actions that are external to an agent in both senses are traditionally considered compulsions.

Most contemporary agency theorists agree that an agent is morally responsible for her weak-willed actions, all other things being equal, because she is the author of those actions even though her behavior does not reflect her deeper, autonomous self. That weak-willed agents are responsible goes hand in hand with the intuition that compelled agents are *not* responsible for their compelled actions. We can thus think of a kind of hierarchy of self-governance. At the bottom are those actions that are fully external and for which the agent bears no responsibility, and which do not reflect anything of substance about her. Next are those actions that are weakly internal, in that they are authored by the agent and are thus ones she is responsible for even if they do not reflect her autonomy. Finally, at the top of this hierarchy is strong internality which is associated with our autonomous attitudes and actions. This hierarchy is frequently (implicitly) assumed by philosophers who develop theories about the particular attitudes relevant for human agency and the relationship between one's autonomy, one's authorship, and one's responsibility.

Historically, moral psychology and philosophy of action have taken the *typical* agent to be their subject.[5] By examining the standard case of human agency we can build theories for how a type of very sophisticated and complex agent can function. These

[4] Weak internality appears to include strong internality in its scope, i.e. if an attitude is internal in the strong sense then it must also be internal in the weak sense.
[5] Ferrero, Luca. "Action" in Shand, John, ed. *Central issues of philosophy*. Wiley-Blackwell, 2009: 137-151.

theoretical models have prima facie appeal in part because they are consistent with what is observed about ordinary human agency – for example, a proper theory of desire must comport with real agents with a myriad of different desires and objects of desire. However, when we apply some of these models – models of moral responsibility, models of identification and internality, models of belief - to other cases of human agency that they should capture, we discover that the models return conclusions that are difficult to reconcile in a reasonable way with the implicit hierarchy described earlier. This mismatch is most clear in the way the standard models of concepts pertaining to internality treat cases of the psychiatric condition of Obsessive-Compulsive Disorder (OCD).

People with OCD experience upsetting thoughts, images, or beliefs that lead them to engage in repetitive actions (compulsions) to alleviate feelings of anxiety. Assuming the hierarchy above, the best way to interpret the actions of the agent with OCD would be as compelled and so not ones for which she is morally responsible. In fact, this is the way OCD is often depicted – as one more example of psychological compulsion which impinges on both freedom and responsibility. Yet, painting OCD as psychological compulsion obscures some of the most interesting – and puzzling – features of the disorder, from the heterogenous way folks with OCD experience their obsessions, to the way these obsessions and attendant compulsive rituals seem to connect deeply to what the agent cares about.

In what follows, I argue that the puzzling conclusions reached when we apply standard models to cases of OCD raise an important question. In order to resolve these inconsistencies, is it our theoretical models that need to be changed or is it the relationship between concepts such as autonomy, responsibility, and authorship that require revision? By investigating this and related questions, being sensitive to the reality of the condition, we can not only better understand OCD as a disorder but also make progress on either shoring up our philosophical theories about elements of agency or building the scaffolding to understand a deeper conceptual error in the relationship between autonomy, responsibility, and authorship.

My dissertation is divided into chapters, with most chapters addressing an apparent complication to an area of philosophy of agency generated by considering cases of OCD and how best to square the reality of the disorder with one particular concept in philosophy of agency. In the first chapter, I present several ways in which OCD (and those with the disorder) have been misrepresented in moral philosophy. In particular, I examine the way many of these representations amount to a sort of epistemic injustice which Linda Alcoff labels 'speaking for' and underscore how insight is an important and oft-overlooked dimension of the disorder. In chapter 2, I revisit some of these misrepresentations with an eye toward critiquing the standard view that people with OCD are not morally responsible because they are not properly responsive to reasons for action. Chief among these is Michael McKenna's caricatured example purporting to show how compulsion is mislabeled as free action by reason-responsive views of responsibility. I argue instead that a proper understanding of OCD, as well as the

requirements of reason-responsive agency, reveal that most folks with OCD fulfill the formal requirements for reason-responsiveness. One reason this has elided philosophers is that OCD has been cast as a kind of failure of reactivity to reasons, whereas I show that the primary deficit is over-receptivity to reasons for action brought about in conjunction with apparent dysfunctional patterns of beliefs. This leads us to conclude that reason-responsive approaches must account for the difficulty in responding to a reason in terms of receptivity, not just reactivity. Otherwise, OCD is either an example of compulsion that is free (in the spirit McKenna feared), or an example of morally responsible agency that is apparently blameless.

In the third chapter, I pivot to considering the concept with which I open this dissertation: identification. I argue that some obsessions experienced by those with OCD fit all the requirements of the attitude of caring, and on at least some theories of caring where these cares are invariably internal to the agent experiencing them, we arrive at the surprising conclusion that those who lack insight into their OCD care about their obsessions even though these agents do not strike us as being robustly autonomous with respect to their obsessions. In the fourth and final chapter, I revisit the idea foreshadowed by earlier chapters that the etiology and maintenance of OCD involves powerful dysfunctional beliefs. Thus far I have been agnostic as to the nature of these epistemic attitudes and have held the provisional assumption that these attitudes are beliefs in the philosophical sense. Yet, a puzzle emerges when we adopt this viewpoint such that none of the present theories about the doxastic attitudes at work in OCD are able to provide satisfactory accounts of the nature of these attitudes. My novel proposal is that OCD

involves what Robert Roberts calls ‘construals’ and that these construals combine with ordinary beliefs to generate the puzzling behavior in OCD. I conclude the dissertation with a discussion of how the insights from each chapter coalesce toward a more accurate, if not more puzzling, understanding of the disorder than philosophers have had thus far, with major implications for future research.

Chapter 1: Misrepresentations of OCD in Moral Philosophy

In *Justice for Hedgehogs*, political and moral philosopher Ronald Dworkin claims that one essential capacity of being a morally responsible person is a kind of purposefulness in life evinced by a mesh between one's motivations and one's actions. Dworkin claims that the decisions a person makes in the absence of this capacity factor into our assessment of how good that life has been. Unfortunately, this leads him to make the following judgments:

> Any period of insanity or deep compulsive obsession endangers the goodness of a life. But when we make the different judgment about whether someone has lived well or badly, we filter out these infirm decisions. A person who is mentally incapacitated for substantially all his life has not, in the ethical sense, lived at all. Others pity him for the horribly damaged life he has endured, but they do not blame him or suppose that if he recovered in time he should blame himself.[6]

It is worth noting that this is Dworkin's revised statement. In a pre-publication manuscript of *Justice for Hedgehogs* Dworkin put it more definitively: "Any long period of insanity or deep compulsive obsession ruins a life."[7] Such treatments of atypical agency generally, and compulsion specifically, are not uncommon in moral philosophy.

In contemporary moral philosophy, especially philosophy of human agency and action, it has become increasingly common for philosophers to reference purported examples of atypical agents who serve the purpose of thought experiments. These

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[6] Dworkin, *Justice for Hedgehogs*, 226–27.

[7] Allen, "Mental Disorders and the 'System of Judgmental Responsibility,'" 621. Allen cites pp. 143 of the original manuscript. Allen's piece is itself an engaging indictment of the way in which academia proper views psychiatrically disabled people in the context of professional life and the life of the mind.

examples are intended to exert pressure on one or more aspects of some theory of responsibility, or freedom, or autonomy. For example, in his famed essay "Freedom of the Will and Concept of a Person," Harry Frankfurt analyzes the concepts of freedom and responsibility using examples of willing and unwilling addicts. Frankfurt does not analyze addiction, or the lives of those with addiction disorders. The role of the addict examples is to further the argument that freedom consists in having the will that one wants to have; they are used as foil for a wider argument about human agency and responsibility. Frankfurt appeals to the bare notion of addiction to a substance and does not concern himself with whether his examples are informed by either the psychology or phenomenology of addiction.

A similar phenomenon has occurred in moral philosophy with respect to compulsion disorders, in particular obsessive-compulsive disorder. Part of this focus on compulsion stems from the importance of self-governance and control in being considered autonomous, morally responsible, etc. as we see in Dworkin's comments about the good of a life. Many representations of OCD in moral philosophy tend toward several problematic roles and practices that undermine both a competent analysis of OCD as well as the epistemic authority of those living with OCD. While not all theorists working on agency and moral philosophy represent these conditions in these ways, when used they generate misunderstanding, ableism, and an overall othering of persons with compulsion disorders.

I begin with a direct report from a person with OCD in order to center the discussion on this lived experience and to introduce several important features of OCD.

From there, I present the way philosophers like Michael McKenna and Timothy Schroeder have either caricatured the disorder or relegated it to a piece of interesting argumentative furniture. These examples from the literature lead to a discussion of the ways in which the voices and perspectives of those with OCD are silenced or distorted when authors fail to engage with the actual words and experiences of those with OCD – an example of a kind of epistemic injustice or what Linda Alcoff calls 'speaking for'. Another distortion in the way OCD is represented philosophically concerns which facets of the disorder are given an outsized influence, such as the sub-type of moral scrupulosity, and which aspects are all but ignored, such as the diagnostic dimension called 'insight'. These misrepresentations and distortions in the literature can be corrected, and I conclude with some suggestions of ways we can modify the way we engage with the experiences of atypical agents like those with OCD.

1. What is Obsessive-compulsive Disorder?

> I stand there and turn the light switch off and on, off and on, off and on, off and on. I can't make myself stop. It's crazy. What happens is that I have the thought that maybe I didn't completely turn it all the way off. Maybe the switch is somewhere inbetween the off and on position and a fire will start because of a short circuit. I know that this does not make sense. Still, I have to keep on switching back and forth until I get it just right. I might stay there for ten or fifteen minutes. One time the light switch started smoking. Now my husband swears at me and yells, 'Leave the light switch alone or you really will start a fire!'[8]

The author of this passage is describing what it is like to experience an obsession and compulsive ritual in the context of obsessive-compulsive disorder (OCD). As they

[8] Osborn, *Tormenting Thoughts and Secret Rituals*, 44. The speaker is an unnamed participant in an OCD discussion group.

switch off the light, the thought occurs - what if that didn't quite do the job? So they switch the light on and off once more. But again, what if *that* one didn't quite turn the light circuit completely off? Doubt and uncertainty have set in. And now the thought occurs: leaving the switch in this position has the possibility of causing an electric fire and great harm. And so, just to be sure, they switch the light on and off again. As they say, they repeat this action of switching the light on and off until 'I get it just right.'

Obsessive-compulsive disorder is a serious and sometimes debilitating psychiatric disorder, with approximately a 2% prevalence in the global population. OCD has traditionally been considered an anxiety disorder, such that in previous versions of the Diagnostic and Statistical Manual of Mental Disorders, OCD was under the heading of anxious disorders. In the most recent DSM 5, OCD is given its own section that includes related disorders (like trichotillomania, body dysmorphic disorder, hoarding, etc.). OCD clusters with related disorders involving urges and dysfunctional beliefs but is also varied in terms of the themes that can manifest in obsessions and compulsions. These related disorders include trichotillomania (compulsive hair plucking) and excoriation disorder (skin picking), which are both marked by bodily-focused repetitive behaviors and an absence of obsessions.[9] For some time, hoarding was considered a manifestation of OCD although this is generally no longer the case.[10] Hoarding is often a symptom of the closely-related Obsessive-compulsive Personality Disorder (OCPD - also called

[9] Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*, 235. There is a live debate in philosophy of psychiatry about natural kinds and whether a taxonomy of psychiatric disorders could 'carve nature at the joints' but this is not an issue I take up here.
[10] Rachman and De Silva, *Obsessive-Compulsive Disorder*, 35–38.

anankastic personality). Individuals with an anankastic personality display rigid perfectionism about the manner in which tasks should be completed, show a marked dislike for granting others even small amounts of control or responsibility, and an overall tendency toward maintaining order. Unlike most people with OCD, those with anankastic personalities generally do not seek treatment on their own because they perceive their behavior to be appropriate.

As its name indicates, persons with OCD typically experience both obsessions and compulsions. Obsessions are distressing thoughts, images, or beliefs that a person experiences which can generate feelings of anxiety. An obsession might consist in recurring upsetting images in one's mind, or recalcitrant uncertainty about one's health or wellbeing, and so on. Most people experience intrusive thoughts infrequently throughout their lives. Obsessions are thought to originate from maladaptive responses to these thoughts, where the person experiencing the thoughts attributes importance or meaning to them.[11] Compulsions or rituals are repetitive or excessive actions (either physical or mental) that a person feels urged to perform in order to assuage her feelings of anxiety. Compulsions need not be conceptually or thematically connected to her obsessions, but in many cases are.[12] Conceptual connections might be that, for example, the person is plagued by distressing thoughts about infection or contamination from touching or being around dogs and feels the urge to repeatedly wash or cleanse themselves.[13] In contrast, in

[11] Hezel and McNally, "A Theoretical Review of Cognitive Biases and Deficits in Obsessive–Compulsive Disorder," 221–22; Veale and Roberts, "Obsessive-Compulsive Disorder," 31–32.
[12] APA, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*, 237.
[13] Henden, Melberg, and Røgeberg, "Addiction," 4; Szalai, "Agency and Mental States in Obsessive-Compulsive Disorder," 50.

a case involving a lack of conceptual connection (which we might think of as means-end incoherence), the person plagued by thoughts or images about being in a traffic accident might have the urge to ritualistically make a certain noise, or perform a mental ritual (like envisioning a certain image), a set number of times or until it 'feels right' to ward off the risk of an accident.[14]

There are competing psychological models of OCD as a disorder that emphasize different aspects of the disorder. Broadly, these models attempt to explain the formation and maintenance of obsessive-compulsive symptoms. Presently, the dominant type of model for representing OCD is the cognitive model. Cognitive models of OCD emphasize the role of various cognitive deficits or differences between the nonclinical population and those considered to have OCD. Cognitive models generally divide into two branches that offer different theories as to how OCD begins, functions, and persists. On one branch, OCD is thought to be the result of dysfunctional cognitive processes whereas on the other, specific dysfunctional beliefs are thought to cause the disorder.[15]

Perhaps the most influential dysfunctional belief model, Paul Salkovskis' cognitive-behavioral model, merges aspects of the behavioral approach to understanding OCD with aspects of the cognitive approach. According to Salkovskis, the essentials of the behavioral model are that obsessions are internal stimuli that generate anxiety in the person experiencing them and which the agent responds to with action(s) to diminish, reduce, or escape this anxiety. This response becomes ritualized over time and its

[14] Szalai, "Agency and Mental States in Obsessive-Compulsive Disorder," 50.
[15] Frost and Steketee, *Cognitive Approaches to Obsessions and Compulsions*, 3.

efficacy in diminishing or dispelling anxiety diminishes, leading to increased repetition. As the agent repeats the rituals, the anxiety from the initial obsession remains. On this model, it is not the intrusive thoughts that cause obsessional and compulsive behavior, but rather the agent's response to these intrusive thoughts that is distorted. [16] As Salkovskis writes:

> According to the cognitive hypothesis, obsessional problems occur when intrusive cognitions are interpreted as an indication that the person may be, may have been, or may come to be, responsible for harm or its prevention. It is this specific interpretation of the occurrence and content of intrusive thoughts in terms of responsibility for harm to oneself or other people which is believed to link intrusions and neutralising (compulsive) behaviors, whether overt or covert.[17]

Here Salkovskis identifies the propensity for persons with obsessional disorders to view the intrusive thoughts they are subjected to through a lens of inflated responsibility for harm as the primary mechanism of the formation of OCD.

There are several specific belief domains that are considered relevant for analyzing OCD from a cognitive perspective. These include responsibility for harm, importance of thought control, threat estimation, perfectionism, and uncertainty tolerance.[18] Perhaps most prominent among these belief domains is *inflated responsibility for harm*, wherein an individual with OCD associates upsetting intrusive thoughts with

[16] C.f. Frost and Steketee, 4–6.
[17] Salkovskis, Forrester, and Richards, "Cognitive–Behavioural Approach to Understanding Obsessional Thinking," 57.
[18] Steketee, Frost, and Cohen, "Beliefs in Obsessive-Compulsive Disorder," 526–28; Sookman and Pinard, "Overestimation of Threat and Intolerance of Uncertainty in Obsessive Compulsive Disorder," 64–67.

being personally responsible for harm to others, oneself, etc.[19] Consider some of these sample statements taken from the Obsessional Beliefs Questionnaire (OBQ-44) alongside the relevant belief domain(s). Respondents are asked to rate how strongly they agree with these and other statements on a scale 1-7:

Obsessional Beliefs Questionnaire OBQ-44

"I should not have bizarre or disgusting thoughts"	Thought importance, control
"It is essential for me to consider all possible outcomes of a situation."	Perfectionism, Intolerance of Uncertainty
"Having violent thoughts means I will lose control and become violent."	Thought importance/control, responsibility
"For me, not preventing harm is as bad as causing harm."	Responsibility, threat estimation
"In order to feel safe, I have to be as prepared as possible for anything that could go wrong."	Intolerance of Uncertainty, Perfectionism

A number of statements on the OBQ-44 demonstrate a preoccupation with personal responsibility for the content and character of one's thoughts, control over one's actions, and the likelihood that harm will occur. Beliefs play a prominent role in most, but not all, manifestations of OCD.[20] Notably, obsessions and compulsions relating to numbering, ordering, counting, and symmetry are rarely accompanied by beliefs.[21] Crucially,

[19] Salkovskis, "Obsessional-Compulsive Problems"; Steketee, Frost, and Cohen, "Beliefs in Obsessive-Compulsive Disorder."
[20] In Chapter 4, I examine the role of beliefs in OCD and the proposals philosophers have given for explaining these attitudes and how they impact cognition in OCD. I hope it will suffice for now to say that these attitudes are at least belief-like.
[21] Brakoulias and Starcevic, "The Characterization of Beliefs in Obsessive–Compulsive Disorder." 155.

although Salkovskis and psychologists frequently reference 'beliefs' in OCD, we should not immediately assume these are beliefs *in the philosophical sense*. We will remain agnostic about the nature of these epistemic attitudes until Chapter 4 where we examine these attitudes in detail.

In the remainder of this chapter, I discuss the specific roles and purposes for which OCD has been used in moral philosophy with an eye toward evaluating the deficits in these representations. These roles sometimes include inaccurate caricatures that oversimplify or underexplain the disorder. In other roles, OCD is used as little more than an argumentative foil for evaluating theoretical or conceptual claims rather than serving as the center of one or more open questions about the nature of human agency. Still other, more clinically informed philosophical treatments of the condition can inadvertently result in placing the author as a mediator between the agent's experience and the reader's understanding. All of these deficits lead us to consider the ways in which we can do better when it comes to representing and analyzing OCD in moral philosophy.

2. The Caricature and The Counterexample

Philosophers concerned with free will and moral responsibility often write about compulsion as the prototypical unfree and 'unresponsible' act. Just as Frankfurt uses the mere notion of addiction, severed from context and the human element, so too do some theorists treat compulsion. For example, in A.J. Ayer's "Freedom and Necessity" he describes a range of different constraints to free action: coercive threats from another person, certain authority-based pressures, impulses in kleptomania, and compulsive neurosis. Regarding such a compulsive disorder Ayer writes, "If I suffered from a

compulsion neurosis, so that I got up and walked across the room, whether I wanted to or not, or if I did so because somebody else compelled me, then I should not be acting freely."[22] In this case, Ayer's reason for citing compulsion is to argue that such a constraint is different in kind from that presented by the threat of determinism. The use of the experiences of those with OCD as a counterexample to some theory is a direct extension of moral philosophers' use of the concepts of compulsion and compulsive behavior in their theorizing. In recent moral philosophy, theorists like Michael McKenna and Tim Schroeder make use of OCD as a foil or counterexample rather than engaging with the disorder 'on the merits'. When philosophers use OCD (or any mental illness/condition) in this way they tend to flatten the complexities of the disorder to better use it in service to some goal divorced from understanding the condition or its impact on people living with it.

Michael McKenna uses the example of a compulsive handwasher in several publications to draw attention to the way in which certain moral theories misrepresent compulsion as free and/or morally responsible behavior.[23] In its most robust form, McKenna's description of this example is a caricature of OCD as a disorder and offensively downplays the reality that many people experience living with OCD. McKenna describes a hypothetical person, Handy the Compulsive Handwasher. McKenna frames Handy as having an extreme, compulsive hand-washing condition, and he does not say that this condition is OCD, or that it is intended to resemble OCD. That

[22] Ayer, "Freedom and Necessity," 116.
[23] McKenna, "Contemporary Compatibilism" 177-8; McKenna, "Reasons-Responsive Theories of Freedom."

being said, it is quite likely that many readers will assume a relation where no explicit one is given. Repetitive handwashing is a common symptom (and one of those most commonly visible symptoms) associated with OCD in public perception. Furthermore, as we will see, McKenna's description of Handy's experience of washing his hands (when it is described) is clearly meant to mimic the triggers that can cue repetitive rituals in OCD.

Handy, McKenna claims, serves as a counterexample to one of the components of a popular theory of moral responsibility, semicompatibilism. I reproduce the entirety of McKenna's description of Handy below:

> Consider a familiar case of unfree action: an agent, Handy, washes his hands from an extreme compulsive hand-washing disorder. Suppose Handy gets his hands dirty one day and washes them. It might be tempting to think that in washing his hands, he does so freely and that this consists in his responding appropriately to a good reason to wash his hands. But as it happens, Handy would have washed his hands at the time whether they were dirty or not in response to any number of whacky reasons. He would have washed them if they were clean and he just saw a garbage truck down the street, if someone within earshot had whispered the word 'germ,' or even if, when his hands were truly dirty, doing so would result in his being seriously injured (suppose for some reason that in the circumstances the only way for him to wash his hands requires breathing poisonous gas). What this suggests is that, in this situation, when Handy washes his hands when they are dirty, it is fortuitous that he does so in response to a good reason. The role of good reasons is not properly integrated with what leads him to action. This in turn suggests that Handy is not in control of his hand washing in a stable way. So he does not wash his hands freely.[24]

Handy washes his hands in response to having his hands dirtied, and having dirty hands is a relevant, 'good' reason to which an ordinarily reason-responsive agent should be both receptive and reactive, *ceteris paribus*. We can shorten this to say that Handy washes his hands when he has at least one good reason to. Handy also washes his hands in light of

[24] McKenna, "Reasons-Responsive Theories of Freedom," 27.

more tangential reasons, which here involve being reminded of germs and uncleanliness (seeing a garbage truck, hearing people talk about germs), but which typical agents do not see as a sufficient reason for handwashing. McKenna contrasts Handy, a compulsive agent, with Dandy, a typical agent, in order to reinforce his argument that something is amiss in Fischer & Ravizza's requirements.

Readers will note that descriptions of Handy's internal epistemic and motivational states is quite spare. The prompts that count as 'reasons' for Handy relate to his perception of contamination-related situations (e.g. seeing a garbage truck, hearing a reminder that germs exist, and having unclean hands with severe repercussions for washing). But we do not know, for example, what Handy's attitudes towards these reasons (or his handwashing) is. McKenna describes these as 'wacky reasons' but from whose perspective? Is Handy perplexed by his own washing, convinced that the sight of a garbage truck is indeed a good reason to wash, or somewhere in between? It seems prima facie important to distinguish between cases where Handy himself thinks "I've got no good reason to wash my hands" and does it anyway, and cases where Handy *himself* believes he has good reason to wash his hands (even if most other agents would say he does not). This is especially true given the influential role of beliefs in OCD.

Another problematic feature of Handy is that the thematic manifestation of his behavior reinforces what is already an over-emphasis on contamination and washing-based OCD behaviors in existing representation. Contamination is certainly a substantive theme in OCD, but it is not the only one and it is not limited to washing one's hands. This points to another aspect of the representation of OCD in philosophy, which is that it has

tended to ignore the vast heterogeneity of OCD's various thematic manifestations. OCD and its related disorders demonstrate wide variation in the manifestation of symptoms, their severity, and their thematic content. This has the result that two persons may both have obsessive and compulsive symptoms that disrupt their lives but which scarcely appear to be examples of the same psychopathology. One person may be experience blasphemous or lewd thoughts which lead her to excessively wash her body. Another may feel driven to check on objects or situations repeatedly to avert perceived disaster, as the author in our passage above 'checks' that the light switch has been turned completely off. Others may fear that they have or will lose control of themselves and harm someone inadvertently or purposefully despite wanting no such thing (e.g. push a stranger into traffic, strike a pedestrian with a car) while 'out of control.' And further still, some may have few if any explicit beliefs related to their rituals, which may concern maintaining order and/or symmetry.[25]

McKenna is not the only moral philosopher to use OCD as a counterexample. In "OCD and Moral Agency," Timothy Schroeder uses a different thematic manifestation of OCD as a putative counterexample against his own theory of agency (a view he calls *spare conativism*.) Moral scrupulosity OCD is sometimes described as 'seeing sin where there is none' since the person experiencing it interprets their behavior or thoughts as sinful or immoral when it is not especially so, or they fear they will act so. Scrupulosity compulsions often concern moral, religious, or guilt-driven behaviors like the repetition

[25] Symmetry-maintenance rituals appear to be an outlier among manifestations of OCD, since this manifestation is less likely to be accompanied by obsessions and dysfunctional beliefs.

of prayers, seeking reassurance or forgiveness from those perceived as moral authorities, etc.[26] Theories like Schroeder's are considered 'neo-Humean' in the emphasis that desires can provide reasons for action. Problematically, neo-Humean theories like Schroeder's have historically had difficulty explaining how compulsions are not examples of acting upon a desire and thus acting for a reason. Schroeder is concerned that examples of moral scrupulosity appear to be examples of a person acting upon a moral reason and thus acting out of a good will and in a praiseworthy manner. If this correctly describes moral scrupulosity, then Schroeder's theory of spare conativism cannot distinguish between free acts and compulsions, a strike against it as a workable theory of agency.

Schroeder draws from two memoirs written by persons with OCD to form the backbone of the cases he considers to be counterexamples to his theory: *I Hardly Ever Wash My Hands* by J.J Keeler and *Rewind, Replay, Repeat* by Jeff Bell. Despite referencing works written by those with experience of the disorder, something which would ordinarily reinforce the lived experience of the condition, Schroeder frames these narratives explicitly as "an apparent lifelike counter-example to [spare conativism], and perhaps to a number of other neo-Humean theories."[27] Schroeder views scrupulosity as a source of more resilient and pressing counterexamples than more classic examples of compulsion in the literature, like Quinn's Radio Man.[28] This reduction to a counterexample is reinforced by the fact that despite citing memoirs, Schroeder does not

[26] Abramowitz and Jacoby, "Scrupulosity," 140.
[27] Schroeder, "Obsessive-Compulsive Disorder and Moral Agency," 89.
[28] Warren Quinn, "Putting Rationality In Its Place," in Value, Welfare, and Morality, edited by R.G. Frey and Christopher W. Morris, (Cambridge: Cambridge University Press 1993): 32-34.

use a single direct quotation from either author about their experiences, opting instead to paraphrase several examples of scrupulous obsessions and compulsions.

Schroeder conceives of moral scrupulosity OCD broadly, eschewing religiously informed examples and tending to focus instead on instances of having caused a harm or wrong. Curiously, although he cites Keeler's *I Hardly Ever Wash My Hands* he does not engage with some of the most relevant examples for his arguments. For example, in contending that scrupulous agents don't care about the underlying focus of their underlying obsession, Schroeder claims that if Bell (or anyone else) with hit-and-run OCD were driven by a genuine intrinsic desire not to hurt others, they wouldn't drive around looking for a victim but would stop driving.[29] But J.J. Keeler and others who have experienced such obsessions often limit how often, when, and where they drive in response to these obsessions, often in ways that cause difficulties in making other engagements, getting to work on time, and so on.[30]

In the most general sense, Schroeder takes scrupulosity to be a particular version of the 'familiar' critique of neo-Humeans as representing compulsion as morally responsible behavior. More to the point, the moral content of scrupulosity obsessions and compulsions appears to provide an example of a compulsion premised on a moral reason:

> Keeler and Bell and others like them display, in their compulsive actions, strong intrinsic desires for what is right or good, it might be said. Thus, by the lights of Spare Conativism and some other neo-Humean moral psychologies, Keeler and Bell and others have good will, because they possess these strong intrinsic desires. When they act on these desires they act for the right reasons, are likely responsible for their actions, and are even (if they act rightly on balance) praiseworthy for their actions. But this is all

[29] Schroeder, "Obsessive-Compulsive Disorder and Moral Agency," 99.
[30] Keeler, *I Hardly Ever Wash My Hands: The Other Side of OCD*, 85–100.

> absurd. People who act out of obsessive-compulsive disorder, even people who act rightly out of OCD, do not act for the right reasons and do not meet key conditions for responsibility and praiseworthiness.[31]

Within Spare Conativism acting with a good will means acting upon an intrinsic desire for what is right. Since this would, mean acting for the right reasons as well, it starts to look like people like Keeler and Bell are morally responsible when they act scrupulously, despite our intuition that agents are not morally responsible for compulsive acts.

This passage reveals the crux of treating cases of OCD, and the lives of those who have OCD, as merely a counterexample. The worth of interrogating the experience is in its service to the furthering of theoretical and conceptual arguments. It is not an investigation into whether, in fact, moral scrupulosity compulsions are morally praiseworthy, or about how we should understand doubt (a common experience in OCD) in the context of normatively charged decision-making. Here there is a semi-expressed presumption that the apparent behavior and motivations of those with scrupulosity cannot possibly be examples of right action although Schroeder never explains why exactly we should presume *this* about scrupulous individuals.

3. Take My Word for It!

Another problematic element of Schroeder's representation of scrupulosity OCD is that despite referencing OCD memoirs almost exclusively, he ultimately adopts a kind of medicalized approach to considering people with mental disorders. This is seen not just in the lack of direct quotes from the authors of the memoirs noted above, but also in

[31] Schroeder, "Obsessive-Compulsive Disorder and Moral Agency," 91.

his concluding suggestion that the best way to confirm his theory would be if we could observe someone with OCD who has an amygdalotomy:

> Fortunately, there is at least hope of empirical confirmation or disconfirmation of the above line of thought. If, for instance, a person showing obsessive-compulsive moral scrupulosity were to have her amygdala removed (an uncommon procedure, sometimes performed for severe epilepsy that resists drug therapy) and were, upon recovery, to show ordinary moral behavior but not continuation of her obsessions and compulsions, then there would be excellent support for the above ideas.[32]

Schroeder believes the amygdala plays a central role in the neuroanatomy of OCD. The idea that removing a 'bad amygdala' could resolve OCD symptoms is overly reductive about the way our brains function, especially with regard to a disorder such as OCD. This is an example of a myth about the nature of OCD.[33] These representations emphasize the symptomology and neurophysiology of the disorder itself and tend to minimize the importance of the lived experience of the disorder.[34]

Another example of this medicalization and the ways in which it can undermine a complete understanding of OCD can be found in some recent work by Walter Glannon. In "Obsessions, Compulsions, and Free Will," Glannon points out that Glbert Meynen's analysis of OCD and control as it relates to free will in philosophy leaves out the most prominent theory on offer: reason-responsiveness. Glannon argues that this view offers

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[32] Schroeder, 101.
[33] Mataix-Cols and Heuvel, "Neuroanatomy of Obsessive Compulsive and Related Disorders," 127–30.
[34] One motivation for this medicalization may be the tendency for philosophers to isolate problems and abstract away from context so as to find solutions that are not contextually bound. For, if philosophy of agency can provide a satisfactory account of the bare phenomenon of 'weakness of will' (for example) then this should hold for all contexts in which the phenomenon appears. Another possible motivation for this medicalization of views stems from the emphasis in the last several decades on conceiving of psychiatry as a branch of medicine.

the most workable conception of control in the form of guidance control. Glannon argues that the features of OCD as a disorder make it such that a person with OCD lacks the ability for free will, and thus for morally responsible agency.

Glannon attempts to map these symptoms onto the reason-responsive view of responsibility. Specifically, he is concerned that "We need a more precise account of what the relevant sort of control consists in, as well as the degree to which OCD diminishes this control in persons who are afflicted with it."[35] Glannon largely relies on the descriptions of OCD provided by an earlier piece by Meynen to which he is responding. However, neither Meynen nor Glannon use any direct reporting from persons with OCD, relying instead on clinical studies that investigate one or more dimensions of the disorder.[36] Consider the language Meynen uses in the only place in which he references the first-person experiences of a particular person, Mrs. X, with OCD:

> She is, in her own words, almost completely in control with respect to the cleaning of her house. Strict cleaning rituals are her daily routine. [...] Even as a child, she explains, she always was a very neat person. [...] Therefore, contrary to Mrs. X's own proclaimed view, she would not be considered to be 'in control' as far as her behavior is understood in terms of OCD.[37]

Note that, as readers, our representation of Mrs. X and her experience is mediated through the voice of the article author. Meynen tells us repeatedly what it is that Mrs. X says *without ever telling us what Mrs. X says.* Another way we might talk about this mediation is that it undermines the epistemic authority of persons with OCD when

[35] Schroeder, "Obsessive-Compulsive Disorder and Moral Agency," 91.
[36] Meynen, "Obsessive-Compulsive Disorder, Free Will, and Control," 322–25.
[37] Meynen, 328.

theorists only paraphrase their experiences rather than using direct reports or whole passages from memoirs.[38]

Epistemic injustices and wrongs are those that concern contexts relating to knowledge, testimony, and authority (broadly). For example, Miranda Fricker distinguishes between different types of epistemic injustices, including testimonial injustices ('prejudiced credence') and hermeneutical injustices (structural and opaque within social contexts). A testimonial injustice would be when the prejudice of a hearer leads him to downplay the validity or authority of the speaker, as when women are not always believed when they speak out about sexual abuse. A hermeneutical injustice would be that the social context of relations between the genders is opaque to those involved and so they lack the concepts and language to address it, as when the state and society do not recognize the possibility and wrongness of marital rape. At issue in representation of OCD is a different form of epistemic injustice, one which constricts the discursive context (perhaps from prejudice or lack of awareness) so as to exclude, adulterate, or otherwise influence the presentation of information.

The idea that 'speaking for another' can have normative dimensions is neither a new idea nor is it unique to representations of OCD in moral philosophy. In "The Problem of Speaking for Others" Linda Alcoff describes this sort of situation as a problem of representation:

[38] Direct reporting does have some limitations when the qualitative data is gathered in a medical setting. For example, the patient should not be able to identify themselves in the data (by legal name or other idiosyncratic features). This does not preclude the use of direct reports or quotations, but it does require a degree of anonymity for the person with OCD.

> Once we pose [the problem of speaking for] as a problem of representation, we see that not only are speaking for and speaking about analytically close, so too are the practices of speaking for others and speaking for myself [...] A kind of representation occurs in all cases of speaking for, whether I am speaking for myself or for others, that this representation is never a simple act of discovery, and that it will most likely have an impact on the individual so represented.[39]

Here Alcoff indicates that any variation of 'speaking for' necessarily impacts representation of the one being spoken for. When philosophers paraphrase the memoirs of authors with OCD, they are speaking for the person with OCD. When philosophers tell us what a person said in her own words without furnishing those words, the authority of the person is undermined because it is implied that they are unreliable or not the appropriate source for this information. This harm of this injustice is only magnified when we reflect on the inaccuracies and incomplete nature of many representations of OCD in moral philosophy. The words of those with OCD are not the only element missing from many philosophical treatments of OCD.

4. Scruple-less Representations?

Few aspects of OCD interest philosophers more than moral scrupulosity. As briefly described above, the behavior of people with scrupulosity OCD superficially resembles conscientiousness, moral virtue, or religious piety. As we see in Schroeder's treatment of scrupulosity, part of his concern is that the explicitly normative content threatens to make scrupulous behavior an example of acting for the right reasons. In another recent philosophical treatment, *Clean Hands*, Jessie Summers presents a

[39] Alcoff, "The Problem of Speaking for Others," 10.

compelling argument for why we should not rush to conclude that persons living with moral scrupulosity OCD are saintly or possess great virtue because of it. Summers begins the book with a discursive comparison of moral scrupulosity with ordinary moral or religious interests before explaining why there is good reason not to consider these as equivalent.[40] Those with this form of OCD have obsessions that concern minor or inconsequential sleights to others (or to God) which they have difficulty dismissing. To relieve their anxiety, those with scrupulosity will often 'confess' to others as a form of seeking reassurance or literally confess in the form of prayer or penance. They might also engage in checking behaviors about their body or mind, seeking evidence of sin or immorality.

Consider the words of Saint Therese of Liseaux, who recalls from her youth her experience with the 'disease of scruples':

> It was during the retreat before my second Communion that I was attacked by the terrible disease of scruples. One must have passed through this martyrdom to understand it. It would be quite impossible for me to tell you what I suffered for nearly two years. All my thoughts and actions, even the simplest, were a source of trouble and anguish to me; I had no peace till I had told Marie everything, and this was most painful, since I imagined I was obliged to tell absolutely all my thoughts, even the most extravagant. As soon as I had unburdened myself I felt a momentary peace, but it passed like a flash, and my martyrdom began again. Many an occasion for patience did I provide for my dear sister.

In this passage, St. Therese describes how she was troubled to no end by obsessions over having done wrong in minor matters, such as tying a fancy piece of ribbon in her hair at the age of 12 (a sinful and childish thing to do, she remarks). Her scrupulous thoughts

[40] Summers and Sinnott-Armstrong, *Clean Hands,* 6-18; 77-92.

lead her to seek reassurance from someone she considers a moral authority, and eventually to shift this to confession in prayer to her deceased younger siblings. St. Therese eventually writes that she was freed from her illness by God. St. Therese's own understanding of her symptoms and experiences is enmeshed within her religious worldview and when we do not consider her own description of it, we lose much of this context.

Scrupulosity's explicit focus on moral considerations is attractive to ethicists precisely because it appears to offer a puzzle about moral motivation and virtue: are the scrupulous moral saints or are they mentally ill? Despite its relative popularity among philosophers, scrupulosity is just one of many thematic manifestations OCD can take. When moral philosophers focus solely on scrupulosity to the exclusion of other manifestations of the disorder, they tend not to emphasize the ways in which manifestations of OCD have commonalities and potentially have a univocal explanation.

5. 'Insight' as an Overlooked Diagnostic Dimension & Marker of Severity

While scrupulosity has an *outsized* influence on how philosophers consider OCD, most philosophical treatments of OCD lack adequate (or any) reference to a particular element of OCD that will become pivotal in later chapters: insight. The psychological concept of insight has, in a sense, always been a part of OCD's diagnostic criteria. For example, in the 1838 volume *Des Maladies Mentales Considérés Sous Les Rapports Médical* by French psychiatrist Jean-Etienne Dominique Esquirol, what we would term 'good insight' is partly constitutive of an OCD diagnosis. That is, in order for a person to be said to have OCD they must in some way see their obsessions and compulsions as

absurd, silly, nonsensical, unreasonable, and so on.[41] As psychiatry has advanced it has encountered a variety of manifestations of the disorders it enumerates, and diagnostic criteria within the DSM have been shaped as much by medical insurance coding as empirical findings.

In the two most recent diagnostic and statistics manuals, DSM-IV and DSM-V, OCD or its equivalent features a diagnostic criterion of insight such that a practitioner can indicate a patient's understanding of their disorder and its impact on their life and functioning. Note that the ICD-10 has no such specifier for insight. Below are the descriptions of the levels of insight listed under Obsessive Compulsive and Related Disorders in DSM-V:

> **With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
>
> **With poor insight**: The individual thinks obsessive-compulsive disorder beliefs are probably true.
>
> **With absent insight/delusional beliefs**: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.[42]

There are several important features of this description of insight in OCD. First, note that poor insight is a diagnostic option, but it is distinct from delusion and psychosis.[43] Second, insight is framed in terms of degree to which the person endorses the *beliefs* she

[41] Marková, Jaafari, and Berrios, "Insight and Obsessive-Compulsive Disorder," 277.
[42] Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*, 237. Emphasis original.
[43] Association, 236.

has in the context of her obsessive-compulsive symptoms.[44] That is, on this description, the object of the person's insight is a particular symptom or set of symptoms.

Somewhat obviously, the presence of several possible depths of insight a person with OCD can exhibit implies that good insight, contrary to Esquirol, is not folded into the diagnostic criteria for OCD. If something like a recognition that one's behavior is senseless or absurd is built into the diagnostic criteria for OCD, a diagnosis of OCD with poor insight poses an immediate classification issue. As Markova et al write:

> Firstly, if insight into OCD is considered intrinsic to the definition of OCD, then recognising the existence of so-called OCD with poor or no insight either simply violates diagnostic rules or calls into question the definitional boundaries of OCD. If the former, one is challenging current diagnostic mores; if the latter, one is thrown back into the 19th century nosological debate that gave rise to the current definition of OCD.[45]

Simply put, if recognition of the absurdity of one's behavior is a constitutive feature of OCD, why do some persons who fit the other diagnostic criteria for OCD lack this kind of recognition about their behavior? And furthermore, how are we to understand the relationship between examples of OCD that differ significantly in terms of the agent's insight?

Some researchers propose that 'insight' be considered a mental state as opposed to a symptom of the disorder. This follows from apparent conceptual issues that arise in the way 'insight' is utilized in both qualitative and quantitative research on OCD. In one particularly penetrating conceptual analysis of insight in general and OCD in particular,

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[44] As we progress through the following chapters, we will use a general notion of belief but remain agnostic as to the nature of these attitudes. In Chapter 4, we revisit this question and investigate the nature of doxastic attitudes in a variety of OCD cases.

[45] Marková, Jaafari, and Berrios, "Insight and Obsessive-Compulsive Disorder," 278.

Ivana Markova et al divide views of insight as either external, intrinsic, or as a mental state. According to Markova, it is fairly common for theorists and clinicians to utilize an external conception of insight in the context of "psychoses, specific neurological disorders and organic brain syndromes," such that diminished insight is itself considered a **symptom** of these conditions.[46]

A patient can be diagnosed with OCD featuring fair or poor insight, and these divisions are intended to assist clinicians in making distinctions concerning the extent and severity of the disorder. There is mounting empirical evidence that, regardless of differences in usage and conception in 'insight' in studies, persons with poor insight in the context of their OCD have overall worse treatment trajectories outcomes. According to a recent 3-year longitudinal study of insight in persons with OCD, approximately 21.7% of persons with OCD demonstrate "an important and stable impairment of the critical capacity and a strong belief in the rightness of obsessive ideas and compulsive behaviors," (which is consistent with previous studies on rates of poor insight). [47] Persons with poor insight so conceived are more likely to have comparatively severe obsessive and depressive symptoms as well as earlier age of onset and increased comorbidity risk than persons with OCD who demonstrate good insight.[48]

Given the overall impact that poor insight can have on an individual's symptoms and the trajectory of her treatment outcome, it is surprising that few philosophers engage significantly with this aspect of OCD. Consider that in *Clean Hands* the term 'insight' is

[46] Marková, Jaafari, and Berrios, 278.
[47] Catapano et al., "Obsessive–Compulsive Disorder with Poor Insight," 327–28.
[48] Catapano et al., 327–28.

not even indexed and plays no substantial role in the theorizing throughout the book. This is true even when seemingly related aspects of OCD are discussed, such as the rigidity with which many scrupulous people approach some of their scrupulous beliefs and rituals. In a co-authored paper that precedes *Clean* Hands, "Scrupulous Agents", Sinnott-Armstrong and Summers do not mention insight. Schroeder does not once mention it "Moral Agency and OCD." In "Obsessive-compulsive Disorder, Free Will, and Control" Gerber Meynen mentions insight once in passing, without explication of the concept or its impact on the person with OCD (or on how we should theorize about OCD cases).[49] In "Scrupulous Agents", Walter Sinnott-Armstrong and Jesse Summers mention insight once, and it is bound up with their labeling of scrupulosity symptoms as largely ego syntonic.[50]

Ego-dystonia and ego-syntonia are descriptions that reference the subjective experience of the person with OCD concerning whether and to what degree OCD symptoms are contrary to their self-conception. In the majority of cases of OCD, obsessions and even compulsive rituals are not conceived of as bringing pleasure, happiness, etc. and there is only a mild sense in which enacting a compulsion can bring relief. Notably, ego-syntonia is not synonymous with poor insight. Ego-dystonia is not synonymous with fair or good insight, either. For example, some experiences of scrupulosity OCD involve a mixture of ego dystonic and ego syntonic thoughts. A person might be plagued by inappropriate ideas or images (e.g. relating to sexual immorality,

[49] Meynen, "Obsessive-Compulsive Disorder, Free Will, and Control," 330.
[50] Summers and Sinnott-Armstrong, "Scrupulous Agents," 956.

religious blasphemy/sacrilege, etc.) which are ego dystonic, given that they are distressing and contrary to the way the agent perceives herself. This very same person may also hold ego syntonic beliefs that are particularly religiously fastidious, or that relate to idiosyncratic interpretations of religious requirements, scripture, and so on.[51]

6. Towards a Balanced Representation of OCD

As we have seen, OCD has often been caricatured, employed as a counterexample, overrepresented in terms of the literature highlighting some thematic manifestations over others, and described in ways that elide important distinctions in terms of the level of insight a person displays into her disorder. Caricatures of the disorder fuel misunderstanding about the phenomenology of OCD and its seriousness as a disorder. Reducing the experiences of those with OCD to serve as a counterexample in an argument renders these experiences as extensions of thought experiments, which can contribute to the othering of those with OCD. Over-emphasizing one thematic manifestation (scrupulosity) over others does not do justice to the heterogenous nature of OCD. Paraphrasing or relying on author descriptions of the experience of OCD undermines the epistemic authority of the very people living with the disorder in question. Omitting distinctions in insight obscures the significant role of beliefs in OCD. Given all of these pitfalls, how are we to best represent OCD in moral philosophy? Below, I suggest several steps that can make representations of OCD in philosophy more accurate and inclusive.

[51] Abramowitz and Jacoby, "Scrupulosity," 141. Something else to note is that pervasive ego syntonia is more representative of obsessive compulsive personality disorder which is marked by such commitment to one's obsessive and controlling disposition.

The first suggestion is to evaluate the perspective from which we philosophize about atypical agency. The very framing of our moral inquiries has important ramifications for what we consider part of the relevant phenomenon being discussed. When theorists use OCD as a foil, this cuts off inquiry into the degree to which agency in the context of OCD is of a kind with the ordinary experience of human agency. Instead, we should consider the ways in which we can incorporate open questions into morality and our moral responsibility practices that are less presumptive about where to locate the experiences of atypical agents. This can improve our theorizing by providing new contexts of considering old questions and clarifying long-standing discussions concerning freedom, responsibility, and control.

Secondly, I suggest theorists incorporate the direct reporting of persons with OCD into our theorizing. When thought experiments (even those that are based on, but different from, the actual experiences of those with OCD) are used, the voices and epistemic authority of persons with OCD is neutered and co-opted. When paraphrases are used in place of direct quotations, important nuance (such as the nature of doubt and beliefs in the context of uncertainty) can be lost or warped. This is particularly important given the historically high rates of misdiagnosis and delayed diagnosis for persons with OCD, who sometimes feel embarrassed or ashamed about their symptoms. Of course, direct reporting is not a guarantee for a completely accurate or objective understanding of something; just because persons with OCD have first-person authority and experience does not mean their perceptions and interpretations should be the sole point of theorizing. Direct reporting should be supplemented with qualitative and quantitative clinical studies.

This preserves the epistemic authority of persons with OCD and renders their testimony as both evidence of, and as part of, the phenomenon itself. This, in turn, will further ground philosophical analysis of OCD as specifically a disorder impacting human agency and moral concerns beyond those restricted to a study of scrupulosity.

Even when it is not possible to use direct reports, we need not abandon present practices of 'speaking for' but, as Alcoff suggests, we certainly should be mindful: "In rejecting a general retreat from speaking for, I am not advocating a return to an un-self-conscious appropriation of the other, but rather that anyone who speaks for others should only do so out of a concrete analysis of the particular power relations and discursive effects involved."[52] In the spirit of Alcoff's suggestion, moral philosophers should endeavor to consider the ways in which they employ representations of atypical agents and the degree to which they are engaging (or failing to engage) with that community.

In the next chapter, we will look in greater detail at the claim that people with OCD are neither free nor morally responsible because they are psychologically compelled. We will analyze OCD through the lens of reason-responsiveness, in particular the claim that folks with OCD are not properly reactive to reasons for action. This analysis will reveal that reason-responsiveness in OCD is much more complex than previously thought and raises serious questions about how we should conceive of compulsion and resistance to compulsions with this newfound understanding of OCD.

[52] Alcoff, "The Problem of Speaking for Others," 24.

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Chapter 2: Reasons and Compulsions

Traditionally, moral philosophers have considered compelled behavior/compulsions to be prototypical examples of unfree action. Where it has been considered, theorists working in moral psychology have argued in support of this traditional conception of compulsion as it applies to obsessive-compulsive disorder. For example, Michael McKenna claims his example of 'Handy the compulsive handwasher' is a counterexample to reason-responsive views of responsibility.[53] Walter Glannon has applied John Fischer and Mark Ravizza's particular theory (henceforth F&R's view) to OCD in order to demonstrate the ways in which persons with OCD lack the control required to be considered free and responsible agents.[54] Yet, the details regarding how persons with OCD deliberate and act in the context of their obsessions and compulsive rituals, paired with their particularly strong subjective judgments that they are effective agents who would be blameworthy for acts or omissions, should give us pause. McKenna caricatures OCD, which leads him to incorrectly conclude that the reason-reactivity component of F&R's view is flawed. Glannon, for his part, mischaracterizes a core feature of semicompatibilist theory, and one which has major implications for the way we conceive of OCD in the context of guidance control. I argue that once we are attentive to an accurate account of OCD, as well as a faithful understanding of reason-responsive responsibility, a novel issue for the moral responsibility debate emerges. Rather than

[53] McKenna, "Reasons-Responsive Theories of Freedom." See also Summers and Sinnott-Armstrong, "Scrupulous Judgments"; Schroeder, "Obsessive-Compulsive Disorder and Moral Agency."
[54] Glannon, "Obsessions, Compulsions, and Free Will."

suffering from a failure of reason-reactivity, such agents are *overly receptive* to reasons, 'seeing' reasons where there are none, or granting them more consideration in deliberation than is warranted. This new view of compulsion raises the question of whether and how moral responsibility and blameworthiness can be mitigated or obviated by an agent being overly receptive to reasons for action, and places pressure on the traditional conception of compulsion as being a mere lack of control.

I begin my laying out the core features of F&R's reason-responsive view, which analyzes freedom and responsibility in terms of an agent's capacity to recognize and react to relevant reasons for action and to act from a 'mechanism' that is her own. From there, I introduce Michael McKenna's critique of F&R's reason-reactivity requirement which is couched in the example of 'Handy the compulsive handwasher'. Problematically, this example is a caricature of obsessive-compulsive disorder which distorts the nature of psychological compulsions by largely omitting their cognitive features. I argue that the poverty of McKenna's example does not undermine F&R's view the way he thinks it does, and leaves open the question of how we are to understand OCD in the context of a reason-responsive theory.

Following that, I establish that OCD has often been miscast as a sort of force and this elides the ways in which the compulsive rituals involved are goal-directed, voluntary, and deliberate actions undertaken by the agent. With a clearer understanding of this aspect of OCD, we can see that many of those with the disorder fulfill the reactivity requirement. In the section that follows, I turn to the receptivity aspect of reason-responsiveness in order to show that the cognitive features of the disorder which are often

downplayed show that many agents with OCD are receptive to an intelligible pattern of reasons for action. When we consider the remaining aspect of F&R's view, 'taking control,' we can see that these cognitive aspects (in the form of dysfunctional beliefs about one's own agency and its efficacy) align with the requirement. What follows from all of this is that a proper understanding of both OCD and the requirements of F&Rs view raises the novel question: how should we conceive of agents who are overly receptive to reasons for action in a way that impacts their agency? I conclude with a discussion of Fischer's idea that these sorts of agents are morally responsible but unlikely to be blameworthy due to the difficulty they have in responding to relevant reasons to act. I suggest that, given the features of OCD, we must have an explanation of 'difficulty' that accounts for over-receptivity to reasons (and the dysfunctional beliefs that support these reasons) if we want to assert that people with OCD are responsible but blameless.

1. Semicompatibilism and Responsiveness to Reasons

One of the most complete and enduring reason-responsive theories of moral responsibility is found in the semicompatibilist theory initially provided by John Fischer and Mark Ravizza (F&R). This approach has been tremendously influential in the free will and moral responsibility literature, and for this reason it is also one of the more developed views (and one with the most developed criticisms and modifications). F&R are motivated in part by skepticism that ultimate sourcehood is required to be free and responsible, and in part by Frankfurt-style examples that purport to show how the ability

to do otherwise is not required for responsibility.[55] This leads F&R to delineate *regulative control* from *guidance control*.[56] Regulative control is a sort of genuine ability to select from different options in a way that we might think common-sense views of freedom require; I could truly go for a walk or stay in and read, and which of these obtains is in fact up to me. Regulative control, in short, means I am a difference-maker. F&R think that what is important for responsibility is that we exercise *guidance control,* meaning an agent does not need to have the ability to have done otherwise in order to be considered free in the relevant way to be held morally responsible for her actions (provided that certain conditions are met).

Guidance control has two fundamental requirements: the mechanism of action must "be the agent's own" and this mechanism must also be "appropriately reason-responsive."[57] F&R analyze guidance control in terms of 'mechanisms of action' rather than in terms of 'agents.' This is due to their commitment to accepting Frankfurt cases, and their view that in such examples the agent is not responsive to reasons, but the mechanism of action within the agent is.[58] Since F&R are in part responding to Frankfurt cases, the ownership over the mechanism of action is seen to be the "normal operation of the human capacity for practical reasoning" rather than some implanted device in the

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[55] Fischer et al., *Four Views on Free Will*, 56. For a more detailed discussion on this pushback against ultimate sourcehood arguments (primarily G. Strawson, Smilansky) see Fischer "The Cards that Are Dealt You."
[56] Fischer sometimes calls regulative control "legislative control", but my understanding is that these refer to the same genuine ability to have done otherwise, to have chosen or acted differently.
[57] Fischer et al., *Four Views on Free Will*, 78.
[58] Fischer and Ravizza, *Responsibility and Control*, 37–40; c.f. McKenna, "Reasons-Responsiveness, Agents, and Mechanisms," 159–63.

brain that can be activated to force a certain decision. Similarly, the mechanism of action (in this case, the agent's practical rationality) must lead the agent to act for what she takes to be reasons in favor of that action, and so must be reason-responsive in a way that an implanted device would not be (since it is designed to override the agent's choice and force a decision regardless of what reasons the agent has for acting).[59] Thus, an agent can have guidance control without having regulative control, and it is guidance control that is required for moral responsibility. In order for an agent to have the capacity for guidance control, she must act from her own reason-responsive mechanism that is *moderately* reason-responsive. We will first discuss what it means for a mechanism to be moderately reason-responsive before turning to the idea of acting from, and taking responsibility for, a mechanism that is 'one's own.'

Reason-responsiveness in general can be broken down into **reason-receptivity** and **reason-reactivity**. Being receptive to reasons concerns the ability to recognize sufficient reasons for some action. Reason reactivity concerns choosing from among the reasons one is receptive to (that is, choosing to act upon one or more reasons you see as sufficient for some act).[60] With respect to the degree of reason-responsiveness required for moral responsibility, the requirements for reason-receptivity and reason-reactivity must be asymmetrical to preserve the possibility of free and blameworthy actions (like

[59] Ibid.
[60] Fischer and Ravizza initially describe reactivity as having two subcomponents, choosing to act in accordance with one or more reason(s) the agent recognizes and acting upon this reason (*Responsibility and Control*, 69).

weakness of will).[61] If moral responsibility required that the set of reasons an agent is reactive to be co-extensive with the set of reasons she is receptive to, then any failure to react to a reason she is *receptive* to will issue in unfree action. F&R settle on moderate reason-responsiveness, which consists of *weak reactivity* to reasons, and *regular receptivity* to reasons. Being weakly reactive entails that the agent can respond to at least one sufficient reason to do otherwise.

To explain and motivate this asymmetry, F&R give the example of Mr. Brown and his affinity for a fanciful substance called 'Plezu.' When taken, Plezu does not generate irresistible desires, but does generate euphoria and extreme lethargy. Suppose that Brown routinely takes Plezu despite being aware of (i.e. receptive to) the strong reasons he has not to take the drug. Additionally, we can stipulate that the only reason Brown would not take Plezu is if he knew that his next dose would be lethal. This reactivity to a single reason is enough, F&R think, to signal that Brown possesses the sort of control required by guidance control.[62] As a result of examples like Brown & Plezu, F&R claim that reactivity is 'of a piece,' meaning if an agent is capable of reacting to one reason then she is capable of reacting to many:

> This reply [to the example of Brown] is based on the fundamental intuition that 'reactivity is all of a piece." That is, we believe that if an agent's mechanism reacts to some incentive to (say) do other than he actually does, this shows that the mechanism can react to any incentive to do otherwise.[63]

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[61] See the discussion and comparisons of the examples of Jennifer, Brown, and the saber killer (Responsibility and Control, 69-76. C.f. McKenna, "Reason-responsive Views of Moral Responsibility," 35).
[62] Fischer and Ravizza, *Responsibility and Control*, 69–70.
[63] Fischer and Ravizza, 73. Several pages later, they write, "Our point is that, holding fixed the actual kind of mechanism, reactivity is all of a piece: if the mechanism can react to any reason to do otherwise, it can react to all such reasons." (74).

This feature of F&R's view has not been received without controversy, and so I will return to this point with regard to reactivity-based critiques of F&R's view.

Regarding the need for a receptivity requirement stronger than weak receptivity to reasons, F&R point to the potential for bizarre or otherwise insensible patterns of reasons an agent could recognize which, intuitively, we would see as invalidating guidance control. For example, Brown may recognize only one sufficient reason not to take Plezu, namely if the dose costs $1,000. But if he is only weakly receptive to reasons, this would be consistent with him failing to recognize that he has as much (and more) reason not to take Plezu if the doses are two or three times that cost. This leads F&R to stipulate that guidance control requires 'regular reason responsiveness' which carries with it the requirement that agents "exhibit a certain sort of pattern of reasons-recognition" that would be intelligible to an outside observer.[64] This notion that cogent patterns of reasons must be recognizable to other agents is not uncommon. A similar requirement, but for intentional action, can be seen in Donald Davidson's early work. For Davidson, reasons for action should provide "an interpretation, a new description of what [the agent] did, which fits into a familiar picture. The picture includes some of the agent's beliefs and attitudes; perhaps also goals, ends, principles, general character traits, virtues or vices."[65]

An additional requirement on reason-responsiveness is that the agent in question be at least receptive to moral reasons, even if she cannot react to those reasons. This

[64] Fischer and Ravizza, 71–90.
[65] Davidson, Donald. "Actions, Reasons, and Causes" in *Essays on Actions and Events*, (Oxford: Oxford University Press, 2002): 9-10.

feature of reason-responsiveness stems from F&R's discussion of psychopathy and whether psychopaths are morally responsible. While F&R are agnostic about the nature of psychopathy, they do say that if there are psychopaths who are unable to even recognize moral reasons for action, they would not qualify as being morally responsible.[66]

In addition to possessing moderate reason-responsivity (in the form of weak reactivity and regular receptivity), having the capacity for guidance control also requires that the agent act from an appropriately reason-responsive mechanism that is *her own*. Fischer & Ravizza characterize ownership in terms of an agent '**taking responsibility**' for acting from a particular reason-responsive mechanism. Taking responsibility in the way required by F&R's view has three components: (1) the agent sees herself as an agent in the world, (2) the agent sees herself as an appropriate target for reactive attitudes, and (3) the beliefs relevant to (1) and (2) are grounded (in the right way) in the individual's evidence about the world around her.[67] Note that this is subjectivist in the sense that moral responsibility requires having a certain self-conception.[68]

When we look to conditions (1) and (2) of taking responsibility for a mechanism of action, we see that it references this kind of self-conception of the agent as opposed to purely objective facts determining responsibility irrespective of the agent's view of herself. When we look to condition (3), we see that it grounds the agent's beliefs

[66] Fischer and Ravizza, *Responsibility and Control*, 78–82.
[67] Fischer and Ravizza, 238.
[68] Fischer and Ravizza, 221.

(minimally) in reality.[69] An important detail about taking responsibility for a *mechanism* is that it is the mechanism taken as it is in reality, not as the agent takes it to be or to the extent the agent takes it to be. As F&R elegantly phrase it, "We take responsibility for the entire iceberg, in virtue of seeing its tip."[70] For F&R, when a person 'takes responsibility' for the ordinary mechanisms of practical reasoning, she need not know the full details of its operation to take responsibility for that mechanism.

To review the preceding, Fischer and Ravizza's semicompatibilist view is an actual-sequence, mechanism-based, moderate reason-responsivity account of moral responsibility. For an agent to have the capacity for moral responsibility by exercising guidance control, she must fulfill a number of requirements. First, she must be able to act from a moderately reason-responsive mechanism (which defaults to the ordinary operation of practical reason). Moderate reason-responsivity breaks down into moderate receptivity and weak reactivity to reasons. Furthermore, the agent must be capable of recognizing moral reasons for acting, meaning she must understand that the welfare, rights, and interests of others provide her reasons for behaving in certain ways and refraining from behaving in others. A morally responsible agent need not have the ability to react to moral reasons, but she does need to be weakly reactive to reasons more

[69] Fischer & Ravizza include this condition originally to explain why a person has not taken responsibility if she has been manipulated into having the beliefs in conditions (1) and (2). Fischer & Ravizza are initially motivated to include this condition to explain why manipulation cases involving a reason-responsive mechanism (with the attendant beliefs) being implanted in a person without her knowledge do not demonstrate morally responsible action.
[70] Fischer and Ravizza, *Responsibility and Control*, 234.

generally (such as prudential reasons for action).[71] The other requirement for guidance control concerns 'taking responsibility' for acting from one's own reason-responsive mechanism. This process concerns the subjective beliefs an agent has about her own causal efficacy in the world as well as the propriety of other agents expressing reactive attitudes toward her (positive and negative). Finally, these subjective beliefs must have come about in light of the agent's available evidence.

2. Existing Discussions of Compulsion & Reactivity to Reasons

One critique of F&R's view concerns sufficient *reactivity* to reasons for guidance control. Al Mele has a critique initially in "Reactive Attitudes, Reactivity, and Omissions" which he continues to develop in conversation with Fischer.[72] Mele provides the example of Fred, whose agoraphobia renders him homebound despite a variety of incentives to leave the house for one reason or another. Fred does not attend his daughter's wedding despite judging he has good reason to, but he does leave his burning home after judging he has good reason to (albeit only with a 'heroic effort'). What's more, leaving his home is a very difficult action for Fred due to his agoraphobia but he is able to react to the reason provided by his burning house (apparently overcoming his fears). [73] Because Fred is weakly reasons-reactive (he can react to the reason provided by the fire), he is reason-responsive in the way required for moral responsibility and so

[71] There is an apparent issue between F&R's discussion on how psychopaths who can recognize but not react to moral reasons are morally responsible and the idea that 'reactivity is of a piece.' Briefly, this may require F&R to deny that such psychopaths are morally responsible.
[72] There is a chronologically prior article by Michael McKenna on a structurally similar point. See McKenna, "Reasons Reactivity and Incompatibilist Intuitions."
[73] Mele, "Reactive Attitudes, Reactivity, and Omissions," 450.

according to F&R's view, Fred is morally responsible for missing his daughter's wedding. This is at odds with widely held intuitions about Fred's case:

> Fred has a terrible psychological problem. His agoraphobia is so severe that, I suspect, the desire he has on his daughter's wedding day to stay indoors would count as irresistible by everyday standards even if he would resist in some scenarios featuring extreme danger.[74]

Mele takes issue with the phrasing of Fischer and Ravizza that Fred is morally responsible but is not morally blameworthy (even though he agrees that these can come apart conceptually). To account for this, Mele suggests that agoraphobia examples, and other potentially functionally equivalent examples of severe psychopathological conditions, can be dealt with by modifying the reason-reactivity condition of moral responsibility to be more substantial.[75] Michael McKenna develops a similar example but with respect to a compulsive handwasher such that it is an apparent counterexample to weak reason-reactivity.

McKenna presents 'Handy the Compulsive Handwasher' as a counterexample against F&R's view.[76] McKenna focuses on the idea that **weak reactivity** only requires "there is some reason to which an agent is receptive that is such that, if it were present, the agent would react to it and act otherwise."[77] Handy, he claims, serves as a

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[74] Mele, "Fischer and Ravizza on Moral Responsibility," 289.
[75] Mele, 290–92.
[76] McKenna offers two descriptions of compulsive handwashers in two different pieces. The least detailed can be found in "Contemporary Compatibilism," in which McKenna depicts the compulsive handwasher as sometimes washing for good reason (or no reason at all) and who is unable to abstain from washing in the presence of powerful countervailing reasons. On this description of the compulsive handwasher, it is difficult to see how acting *for no reason at all* could factor into an intelligible pattern of reason-recognition. For this reason, I focus on the more developed example of 'Handy'.
[77] McKenna, "Reasons-Responsive Theories of Freedom," 35.

counterexample to weak reasons-reactivity as a sufficient condition for moral responsibility.[78] The following is McKenna's description of Handy:

> Consider a familiar case of unfree action: an agent, Handy, washes his hands from an extreme compulsive hand-washing disorder. Suppose Handy gets his hands dirty one day and washes them. It might be tempting to think that in washing his hands, he does so freely and that this consists in his responding appropriately to a good reason to wash his hands. But as it happens, Handy would have washed his hands at the time whether they were dirty or not in response to any number of whacky reasons. He would have washed them if they were clean and he just saw a garbage truck down the street, if someone within earshot had whispered the word 'germ,' or even if, when his hands were truly dirty, doing so would result in his being seriously injured (suppose for some reason that in the circumstances the only way for him to wash his hands requires breathing poisonous gas). What this suggests is that, in this situation, when Handy washes his hands when they are dirty, it is fortuitous that he does so in response to a good reason. The role of good reasons is not properly integrated with what leads him to action. This in turn suggests that Handy is not in control of his hand washing in a stable way. So he does not wash his hands freely.[79]

Handy washes his hands in response to having his hands dirtied, and having dirty hands is a relevant, 'good' reason to which an ordinarily reason-responsive agent should be both receptive and reactive, *ceteris paribus*. We can shorten this to say that Handy washes his hands when he has at least one good reason to. Handy also washes his hands for reasons that he takes to be good reasons, which here involve being reminded of germs and uncleanliness (seeing a garbage truck, hearing people talk about germs), but which typical agents do not see as a sufficient reason for handwashing. [80] McKenna points out

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[78] Ibid.
[79] McKenna, "Reasons-Responsive Theories of Freedom," 27; Mckenna gives the same argument, without the colorful example, in McKenna, "Contemporary Compatibilism," 177–78.
[80] Further evidence that Handy is intended to represent a case of OCD emphasizing contamination is that contamination is one of the central themes represented in OCD, with compulsive handwashing also being one of the most prevalent representations of compulsion in popular media.

that Handy is reactive to some reasons, but not to others and so fits the bill for being weakly reactive to reasons, and thus morally responsible despite being compelled. For example, Handy *won't* wash his hands if his child's life is threatened, but he *will* wash his hands even if he is told he will thereby breathe toxic gas. Note the structural similarity between Handy and Fred (with agoraphobia in a burning home) above. In both examples, the agent is capable of reacting to at least one reason (to leave his home/to abstain from washing), but seemingly unable to react to what appear to be similarly-weighted reasons for the same action.[81]

McKenna's argument fails along two primary dimensions. The first is that it is not entirely clear that Handy is an effective counterexample to F&R's view. Recall that for an agent to be regularly reason-receptive in the way required, she must exhibit an *intelligible* pattern of reason-recognition. This pattern is not just intelligible to a potential outside observer but is also minimally connected to reality. This prevents patterns of reason-recognition from 'counting' when they are not properly rooted in the world around us and when they are inscrutable to other agents. This is evident in Fischer & Ravizza's example where Jennifer considers a ticket price of $100 as a reason not to attend the show but does not consider a ticket price of $101 a reason not to attend the

[81] McKenna claims that in *Deep Control,* Fischer accepts the points demonstrated by the Fred and Handy examples, acknowledging that the reactivity component of F&R's view must be somewhat stronger than weak reason-reactivity. However, McKenna overstates this point. In "The Free Will Revolution (continued)," and *Deep Control*, Fischer does not explicitly endorse a strengthening of the reactivity component of moderate reason-responsiveness. Fischer is cautious with examples like Fred, indicating that these are indeed difficult cases, and ones that *may* call for a kind of revision along the lines of what Al Mele suggests. See McKenna, "Reasons-responsive Theories of Freedom," 36 and Fischer, *Deep Control*, 191.

show. Presumably this is unintelligible because there are no clear grounds upon which the price of $100 per ticket does not function as a 'ceiling' price, treating any price higher than that as providing a reason not to attend. Fischer & Ravizza indicate that such a pattern "raises the question of whether Jennifer, in exhibiting this pattern of counterfactual response, can be held morally responsible at all."[82] In order for Handy to be an effective counterexample, he needs to not only be able to react to one relevant reason to do otherwise, he must also present a minimally sensible pattern of reasons that he recognizes, as assessed from some the perspective of third-party observer who can take on his perspective.

There is a lack of information about Handy's internal epistemic and motivational states. The prompts or cues that count as 'reasons' for Handy relate to his perception of contamination-related situations (e.g. seeing a garbage truck, hearing a reminder that germs exist, and having unclean hands with severe repercussions for washing). But we do not know, for example, what Handy's attitudes towards these cues or reasons (or his compulsive handwashing) are. Is Handy perplexed by his own washing, convinced that the sight of a garbage truck is indeed a good reason to wash, or somewhere in between? It seems prima facie important to distinguish between cases where Handy himself thinks "I've got no good reason to wash my hands" and does it anyway, and cases where Handy *himself* believes he has good reason to wash his hands (even if, objectively, he does not). This is because reason-receptivity is more than just the presence of reasons - it is the recognition by the agent that some consideration is relevant for her deliberation. If Handy

[82] Fischer and Ravizza, *Responsibility and Control*, 67–68.

is estranged from the reasons he recognizes for action, it is difficult to understand how he could exhibit guidance control. Similarly, if Handy takes seeing a garbage truck as a relevant reason for washing, we need more information about how this fits into his overall pattern of reasons and his conception of himself as an agent. This is also particularly important given the framework within which McKenna is working; F&R's view has a number of subjective elements that turn upon the agent's self-conception and beliefs about her own agency.

The second dimension along which McKenna's counterexample fails is by the lights of one of his own desiderata for compatibilist theories of responsibility. In "Contemporary Compatibilism," McKenna claims that compatibilist theories have the argumentative burden that "[they] offer a plausible theory of freedom applying to actual persons."[83] It should not be the case, McKenna argues, that compatibilist conceptions of agency provide theories that are unrealistic or impossible to map on to real agents in the world. This burden ought to apply not just to the typical agents under consideration but the atypical agents as well. By putting forth Handy as a counterexample to F&R's view (in the form of a compulsive agent apparently acting freely), McKenna seems to imply that Handy maps on to real agents in the world. However, McKenna's description of Handy is not representative of the behavior of actual agents with compulsive disorders. Instead, it is a misrepresentation that does not apply to actual persons. I am inclined to think that the degree to which McKenna's example of Handy departs from the reality of OCD will also be the degree to which his own example is inadequate. Without a faithful

[83] McKenna, "Contemporary Compatibilism," 182. See also p. 176.

example of compulsion we are limited in what conclusions we can draw from the example of Handy.

Thus far, we have seen that a central critique of F&R's view - that it faces problems stemming from its conception of reactivity to reasons - is driven by a counterexample that purports to show compulsive agents acting freely and in ways for which they are morally responsible. Handy is described as a compulsive handwasher who is only able to react to a single, dire reason to do otherwise (such as the imminent execution of his loved ones). McKenna thinks this is enough to spoil F&R's view's conception of reason-reactivity, yet I argue that the counterexample does not work for two distinct reasons. First, it is not clear upon the description of Handy that he fulfills the *other* requirements of guidance control beyond reactivity. Second, Handy does not describe actual compulsive agents. To see this, in the sections that follow I show how Handy is not representative of OCD by detailing the features and phenomenology of OCD. We will begin by considering reason-reactivity. This will position us well to consider how we should properly conceive of compulsive agents within F&R's view.

3. Compulsive Rituals and Reasons-Reactivity

One important dimension of recent research on the cognitive aspects of OCD is the role dysfunctional beliefs play in both the etiology and maintenance of the disorder. There are several specific belief domains that are considered relevant for analyzing OCD from a cognitive perspective. These include responsibility for harm, importance of

thought control, threat estimation, perfectionism, and uncertainty tolerance.[84] Perhaps most prominent among these belief domains is *inflated responsibility for harm*, wherein an individual with OCD associates upsetting intrusive thoughts with being personally responsible for harm to others, oneself, etc.[85]

OCD has tended to be presented in the philosophical literature as one of several forms psychological compulsion can take. These forms of compulsion are viewed as constraints on free action - a force or inhibition that limits or controls action.[86] The assumption that compulsion constrains free action is the reason why, for example, Michael McKenna frames his counterexample to F&R's view (Handy the compulsive handwasher) as an example of compulsion labeled as free and responsible action, why Tim Schroeder describes scrupulosity OCD as an even stronger counterexample to his view than Quinn's ridiculous Radio Man, etc. This mis-construal of the way compulsive rituals work in OCD has resulted in inaccurate analysis of the disorder and its relation to agency.

There are several reasons to suppose that people with OCD generally have sufficient reason-reactivity for moral responsibility. The first and strongest piece of evidence is that compulsions are themselves conscious, deliberate, voluntary actions undertaken by the agent. Compulsive rituals are not a yolk placed on an agent's neck by

[84] Steketee, Frost, and Cohen, "Beliefs in Obsessive-Compulsive Disorder," 526–28; Sookman and Pinard, "Overestimation of Threat and Intolerance of Uncertainty in Obsessive Compulsive Disorder," 64–67.
[85] Salkovskis, "Obsessional-Compulsive Problems"; Steketee, Frost, and Cohen, "Beliefs in Obsessive-Compulsive Disorder."
[86] Ayer, "Freedom and Necessity."

her disorder. Rather, they are the product of the agent's desire to avoid causing harm to others or themselves, paired with her uncertainty about the likelihood of risk and her responsibility for harm (which can take the form of a variety of dysfunctional beliefs). As Henden et al write:

> Compulsive behavior in clinical cases seems intentional and related to active choice. As one researcher remarks, in typical cases of OCD the person often carries out her compulsive behavior quite deliberately, taking particular care to carry it out precisely as she feels it ought to be done.[87]

People with OCD feel driven to engage in compulsive rituals as a means of averting harm to others and of relieving intense feelings of anxiety and guilt stemming from a real or imagined risk or harm.[88]

Those with OCD often go to great and painful lengths to prevent the remotest or most unrealistic harms from befalling people, even strangers. Judit Szalai documents this in her piece "Agency and Mental States in Obsessive-Compulsive Disorder." Regarding the (now familiar) idea that only the threat of death or extreme harm will motivate a person with OCD to leave her burning house, Szalai writes:

> A person with OCD will not find herself unable to get out of bed owing to some force, including her own desire, as a result of her condition. The only way in which it could hinder her escape from the burning house is the unlikely possibility that she has a ritual attached to the very activity of getting out of bed or one that she performs while staying in bed and is unwilling to break off or forgo, even in extreme danger. Her reasons will be intelligible in the light of her beliefs, even if we consider those beliefs irrational.[89]

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[87] Henden, Melberg, and Rogeberg, "Addiction," 3. Cf. Taylor et al., "Do Dysfunctional Beliefs Play a Role in All Types of Obsessive–Compulsive Disorder?," 86.
[88] Henden, Melberg, and Rogeberg, "Addiction," 6.
[89] Szalai, "Agency and Mental States in Obsessive-Compulsive Disorder," 51. I return to this idea of intelligible reasons from irrational beliefs.

We can see this at work in first-person accounts of what it is like to experience OCD. For example, Dr. S recounts being plagued by the thought that he could have unknowingly struck a person with his car. Despite being headed to an important exam, Dr. S loops back around on the highway and repeatedly scours the side of the road for signs of carnage he may have caused. But here, Mr. S is not doing so because he must. Rather, the conjunction of doubt and anxiety that he may have caused an accident - and the stakes of having caused such an accident - influence his deliberation and lead him to think that this is what should be done. Some may be confused by this description of the scenario, since Dr. S is clearly distressed by his obsessive thoughts of collisions: "I think to myself, 'Rush to check it out. Get rid of the hurt by checking it out. Hurry back to check it out. God, I'll be late for my final exam if I check it out. But I have no choice. Someone could be lying on the road, bloody, close to death.'"[90] Dr. S is unhappy, even embarrassed, to be seen by the patrol officer checking the shoulder of the road. This is because OCD symptoms are usually ego-dystonic, meaning they run contrary to the agent's self-conception and desires. But this distress is fueled by the role doubt plays in OCD deliberations. Dr. S is shaken by the mere possibility that he may have unknowingly hit someone and would thereby be responsible for a great harm. This thought grows as he reflects on how terrible it would be if he truly did strike and kill a pedestrian.[91]

[90] Rapoport, *The Boy Who Couldn't Stop Washing*, 24.
[91] In the DSM and many other texts on OCD, there is reference to the beliefs that underlie OCD and the agent's attitude toward these beliefs. Philosophically, however, it is not clear whether these are proper beliefs or if these are belief-like features of complex emotional attitudes.

Similarly, J.J. Keeler describes the moment her hit-and-run obsessions began as hearing on the news a single time that sometimes hit-and-run drivers don't know they caused a collision or a fatality. Keeler gives an informal etiology in her memoir of how the seed of doubt took root:

> This all began one evening with the report of a man who caused a fatal crash just north of Colorado Springs. He had abruptly changed lanes, cutting off an unsuspecting car and forcing it to swerve into another lane. As a chain reaction ensued, he drove off, leaving a tangle of cars to suffer the mess he caused.
>
> As horrible as the accident was, it wasn't the accident itself that caught my attention. Instead, it was something the news reported: the driver might not have been aware of what happened.
>
> [...]
>
> This was one of those moments when your world freezes, when you look at the clock in the kitchen and swear the second hand has stopped, when you feel as if you've unleashed a pack of dogs you'll never be able to catch. The instant these words came out of [the news anchor's] mouth, I knew I'd look at driving in a different light.
>
> Almost immediately, I began to fear that I, too, would cause an accident without realizing it. Soon, my driving habits began to change drastically. [...] This created a turning point in my life. Before I knew it, driving obsessions were burrowed in my brain like cockroaches: sneaky, lingering, and forever multiplying.[92]

The origin of this fear of unknowingly causing an accident is learning that sometimes car collisions can occur without the driver who caused it being aware of what they have done. Keeler considered that perhaps she, too, could have done this or may do this in the future and so the risk warrants taking certain steps to mitigate a collision from happening. This sliver of possibility is enough to feed

[92] Keeler, *I Hardly Ever Wash My Hands: The Other Side of OCD*, 89–91.

the obsessive thoughts and to dress the compulsive rituals as being necessary, safe, or even reasonable.[93]

The second piece of evidence that compulsions are voluntarily and consciously performed comes in the form of clinical evidence that people with OCD are able to stop a compulsion or delay completing it (despite accompanying distress). Anecdotally, Dr. S is able to disengage from his checking in order to take his exam (although the obsessions continue) and he returns to the highway to check after his exam is over. Szalai argues the relative success of Exposure Response Prevention therapy (ERP) for people with OCD demonstrates this ability to refrain or stop a ritual. In ERP, a person slowly and purposefully exposes herself to obsession-related stimuli, ideas, etc. For example, if we suppose that a person fears when they touch a knife that they may unwillingly hurt someone, then a low-level exposure might be briefly holding an otherwise harmless sharp object for a period while standing in a room with someone. As the person becomes more comfortable with this exposure, a more difficult exposure is provided until the agent is able to refrain from rituals outside of exposures. The goal is to slowly alter the person's responses so as to reduce anxiety and promote confidence in the face of uncertainty and fear. Szalai points out that in ERP therapy, persons with OCD are tasked with resisting or not initiating the compulsive ritual. Many patients engaging in ERP therapy are able to abstain from compulsive rituals for the duration of the exposure, and 'failures' of ERP

[93] Nestadt et al., "Doubt and the Decision-Making Process in Obsessive-Compulsive Disorder," 2.

therapy are instances where the patient does not want to engage in the exposure because they consider too unsafe, and too likely to cause harm.[94]

Since people with OCD experience a gamut of obsessive and compulsive symptoms that can change in severity over time and in response to life experiences, some with OCD may be practically unable to engage in ERP therapy until some other intervention is introduced or accompanies it (such as medication or deep brain stimulation devices). Those with OCD who are the most ill, like Mr. A who became homebound spending hours upon hours completing compulsive rituals every day, may not meet the reactivity component without other therapeutic interventions.[95] But since (1) most cases of OCD are not as severe as Mr. A's and (2) ERP therapy is generally effective in combatting OCD symptoms, we can say that most people with OCD meet the minimum reactivity component of the capacity for guidance control.

Yet, this is only part of the story. While McKenna is 'right' in the sense that both Handy and most people with OCD meet the reactivity component of guidance control, Handy is not a faithful example of a person with OCD. Furthermore, the reactivity component is just one feature of guidance control. For an agent to have guidance control, she must not just have a minimal capacity to react to reasons. She must also display a pattern of reason-recognition that an external observer who can take her perspective finds intelligible. She must also 'take responsibility' in the sense of having certain beliefs about

[94] Szalai, "Agency and Mental States in Obsessive-Compulsive Disorder," 51–52.
[95] Bosanac et al., "Identity Challenges and 'Burden of Normality' after DBS for Severe OCD," 3.

her own agency. I now turn to the ways in which people with OCD are not only moderately receptive to reasons, but the ways in which they are overly receptive to them.

4. Reasons, Reasons, Everywhere: Receptivity to reasons in OCD

OCD spoils reason-responsiveness, not by disabling it, but by flooding one's deliberation with particularly powerful reasons for action or a litany of smaller considerations that the person with OCD perceives to be relevant or effective. Recall that there are several specific over-active belief-domains that characterize OCD: responsibility for harm, the importance of controlling one's thoughts, over-estimation of threats, perfectionism, and tolerating uncertainty.[96] Below I argue that the activity in these belief-domains tends to lead a person to view considerations as reasons which they would not ordinarily consider, or to weigh reasons more heavily than they might otherwise.

Let's look at the operation of some of these belief-domains as a person with OCD experiences it, based on her own reporting. The following excerpts are from a *Huffington Post* piece by Windsor Flynn in which she describes her experiences with post-partum themed OCD:

> I was comfortable with my baby, and we bonded immediately. I knew how to soothe him when he was upset and breastfeeding came easily to me.
>
> [...]
>
> But I was consumed by the idea that something would happen to him. To calm myself, I did everything in my power to make sure he was safe - and I mean everything. I held him while he slept so I could feel his breathing. I made sure I was his main caretaker so that I could keep an eye on him at all times. [...] I had exhausted all safety measures and had eliminated any

[96]Steketee "Beliefs in Obsessive-Compulsive Disorder" 526-528; Sookman and Pinard "Overestimation of Threat and Intolerance of Uncertainty in Obsessive Compulsive Disorder"64-67.

> external threats in my control, but I still had the gnawing feeling that something bad would happen. I could think of nothing worse than causing harm to my own child, so I turned my focus inward and started to monitor myself, just to make sure it wasn't me who would hurt him.
>
> [...]
>
> Even though it was the last thing I wanted to do, I started imagining all the possible ways that I could hurt him. The images came involuntarily and fast, like a TV screen flashing before my eyes. Everything I saw gave my imagination more to run with. The bathtub brought images of me drowning my baby. When I walked past the railing on the second floor of my home, I felt a pang of fear in case I threw him down. If I stood too close to a window, I saw myself opening it and letting him fall to the ground.
>
> [...]
>
> It was like a recurring nightmare but my eyes were open. I didn't want to hurt my child, but I was having violent thoughts of doing so.
>
> [...]
>
> So I lived with the fear and the guilt and the violent thoughts and did what I could to lessen my anxiety. I reminded myself every second that I loved my baby, and that moms who love their babies don't kill them. I spent most of my time in public places so that in case I went mad, someone out there would notice and hopefully save him from me.[97]

In Flynn's powerful recounting of her obsessive-compulsive symptoms, we see many of the aforementioned belief-domains at work.

Flynn experiences an overestimation of threats to her newborn when she holds him while he sleeps and when she engages in a variety of other actions aimed at warding off an unlikely threat. Note that it is possible for newborn children to pass away during sleep due to a condition like Sudden Infant Death Syndrome, but the likelihood of this has decreased over time. According to CDC data, SIDS deaths have decreased from a rate of 130.27 out of every 100,000 children in 1990 to 35.18 out of every 100,000 in 2018.[98]

As Flynn eliminates external threats to her child, she begins to overestimate the

[97] Flynn, "After Giving Birth, I Had Violent Thoughts About Hurting My Baby. Now I Know Why. | HuffPost."
[98] "Data and Statistics for SIDS and SUID | CDC."

threat she herself poses to her baby. She experiences intrusive thoughts of a violent nature concerning her child, and her reaction is to treat this as a reason to change her behavior. Furthermore, many (but not all) of these intrusive thoughts involve, or are triggered by, her perception of a risk: when she bathes her child, the images concern her drowning her baby, when she walks by a rail the images concern throwing the baby, and so on. Flynn changes her behavior in response to these obsessions, ensuring she is not alone with her baby for very long and that she is around people who will stop her if she somehow goes 'mad' and harms the child. This reflects an obsessional belief concerning not just Flynn's level of responsibility for her child's welfare but also the importance she grants to controlling her thoughts. Compare this to a sample statements from the Obsessional Beliefs Questionnaire OBQ-44: "Having violent thoughts means I will lose control and become violent,"; "If I have aggressive thoughts or impulses about my loved ones, this means I may secretly want to hurt them,"; "Having intrusive thoughts means I am out of control,"; "Harmful events will happen unless I am very careful." Flynn's perception of herself as a risk to her child is the product of the belief domain concerning the importance of thought control. It is important to note that a particular token OCD belief often reflects overactivity in more than one belief domain. Many of the actions Flynn takes to protect her child from harm are also representative of a significant intolerance of uncertainty. This is particularly true when Flynn begins to consider these sorts of beliefs as potentially indicative of her character or what she is liable to do. It is in light of her taking the obsessional thoughts as even potentially reflective of what she may do that her compulsive rituals begin to make sense in a minimal way.

In Flynn's case, we see that her obsessions (in the form of intrusive thoughts) present her with what she takes to be reasons for acting in a minimal sense. That is, obsessions and their triggers (when present) appear to be considerations counting in favor of some course of action. She perceives her fear that her child will pass in its sleep as a reason to hold her baby as it sleeps. She perceives her fear that she will drown her child as a reason not to be alone while bathing it. She perceives her fear that she will lose control, 'go mad,' and harm her baby as a reason to spend as much time in public with her child as possible. In this way, when in the grips of her OCD Flynn appears to treat her obsessions as reasons for action, and reasons which appear (to her) to outweigh other more (objectively) reasonable courses of action.

Note the pattern of reason-recognition that Flynn evinces in her descriptions of her symptoms. In this case, there is a standard means-end relationship between the content of her obsessions and the compulsive steps she takes to avert the events she fears from coming to pass; when Flynn fears her child may drown, she attends to it while it bathes. When she worries she may drown her child while it bathes, she removes herself from the situation or ensures her behavior is under the watchful eye of someone she trusts. When she fears she may have some kind of mental or psychotic break and harm her child, she spends time in public where others would surely intervene if she were to act on these thoughts. When we focus only on the pattern of reasons Flynn recognizes for action, we can see that it is intelligible in the sense that external observers are able to understand her reasons for acting. We may judge that she is mistaken about what reasons she has for acting, e.g. that her fear her child may die in the crib is unwarranted by the

available evidence and so she need not hold the child all night long. But we can understand that this fear, if taken seriously, warrants some kind of action along the lines of what Flynn undertakes.

Part of the reason why Flynn's behavior qualifies as reason-responsive when Handy's does not is because, although her perception of risk and probability is skewed toward prohibitive risk-avoidance, there is a Davidsonian intelligibility revealed in her narrative about keeping her child safe. Although we know her fear to be greatly exaggerated, we can understand her behavior and place it in in the larger tapestry of her life. For example, suppose a friend notices that Flynn has asked to spend time in the park with her and her child every single day for the last two weeks and seems distressed when her friend is not available to join her. If she were to ask Flynn why she has such a strong desire to go to the park together so often, Flynn's honest answer would be that she fears she may harm her child if she is alone with it even though she wants to do no such thing. While her friend may view this as unreasonable, that does not mean it is not intelligible. Her friend now understands, in the Davidsonian sense outlined earlier, how to place Flynn's behavior in the broader scheme of Flynn's agency and life.

One aspect of OCD which we should be careful to note is that not all obsessions are thematically linked to the compulsive rituals that follow, although many are. For example, a person may believe that if she does not hold a particular image in her mind while engaged in certain activities, some unfortunate harm will occur to her or others. This behavior may be unrelated to the content of the obsession or the image the person feels compelled to envision. This sort of behavior presents as means-end incoherence: the

actions the agents perceives to be means to her desired end are not sufficient to achieve that end or are not related to that end. When a person with OCD has obsessions and rituals which demonstrate this kind of means-end incoherence, it is less likely that their overall pattern of reason-recognition is going to be intelligible in the way required by F&R's view.[99]

I have argued that many people with OCD (but not all) fulfill the requirement of being reason-responsive, not just with respect to reactivity but to receptivity and the overall intelligibility of the pattern of reasons for action they recognize. Contrary to the descriptions of addictive compulsion that F&R provide, people with OCD do not demonstrate a failure of reactivity so much as they demonstrate a dysfunction of receptivity. Due to the belief domains at work in the manifestation of OCD symptoms, persons with OCD perceive reasons for action that typical agents do not. Yet, reason-responsivity is only one half of guidance control, and so we still have not answered our question of what reason-responsive views have to say about persons with OCD. In the next section, I discuss the remaining component, that of 'taking responsibility.'

5. 'Taking Responsibility' in OCD

In "Obsessions, Compulsions, and Free Will," Walter Glannon responds to Gerben Meynen's piece on the relationships between free will and OCD. Glannon, for his part, points out that Meynen does not discuss the most prominent approach, F&R's view

[99] There is active debate about whether robust examples of delusional belief are appropriately diagnosed as OCD with poor insight. For some examples of people who display delusional beliefs in a pattern of OCD, see O'Dwyeer, Anne-Marie and Isaac Marks, "Obsessive-compulsive disorder and delusions revisited".

and aims to remedy this. Glannon argues that when we map the features of OCD onto a reason-responsive understanding of freedom, we can see how it is that persons with OCD lack guidance control and thus are not morally responsible. Yet, the way in which Glannon conceives of the requirement in F&R's view that agents 'take responsibility' leads him to incorrectly assess whether persons with OCD meet this particular requirement. While discussing guidance control, he writes,

> an agent must have the capacity to take responsibility for the mental states issuing in his actions. One takes responsibility for these states when one has the capacity to critically reflect on, evaluate, and accept them as the authentic springs of one's actions. In this way, one comes to identify with or endorse them as one's own.[100]

Glannon goes on to say that this is similar to Frankfurtian identification, and satisfaction, with a second-order desire:

> This account [of taking responsibility] is similar in many respects to the earlier accounts of identification and free will developed by Harry Frankfurt [...] Identification results from a process of critical self-reflection, after which the relevant desires become part of the total set of a person's mental states.[101]

This characterization of 'taking responsibility' as explicit, reflective identification is inaccurate on several fronts.

First, identification of the kind Frankfurt describes is more appropriately classified as autonomy-identification. In "Mission Creep" Fischer points out that whatever identification might take place with respect to responsibility, this is distinct and separable from identification that relates to autonomy.[102] Second, Fischer himself does

[100] Glannon, "Obsessions, Compulsions, and Free Will," 334.
[101] Glannon, 334.
[102] Fischer, "Responsibility and Autonomy," 175.

not work with the concept of identification within F&R's view and it is unlikely he would accept this characterization of 'taking responsibility.'[103] Finally, this characterization of 'taking responsibility' is contrary to what Fischer and Ravizza say regarding how active this process is:

> Our account of taking responsibility requires that an agent come to have a certain cluster of dispositional beliefs about himself. He need not put these beliefs into words appropriately, nor need he explicitly deliberate about the beliefs, entertain them, or otherwise be consciously aware of them.[104]

Thus, not only is 'taking responsibility' distinct from Frankfurtian identification, it is also not as explicitly cognitive in that it does not require conscious or reflective confirmation. This misconception of 'taking responsibility' has downstream impacts on Glannon's analysis, since he treats Frankfurtian satisfaction as equivalent to 'taking responsibility' when it comes to being the source of one's actions.[105] It is a mistake to think that guidance control requires that agents reflectively endorse higher-order attitudes in evaluating whether they 'take responsibility' in the way required by the theory.

To review, an agent 'taking responsibility' amounts to holding two beliefs: (1) that she is an effective agent in the world who is (2) sometimes the appropriate target of the reactive attitudes of others.[106] These beliefs do not need to be reflectively endorsed or explicitly articulated, but they do need to be formed based upon the evidence available to the agent about the world around her.[107] With this corrected understanding of 'taking

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[103] Fischer, email message to author.
[104] Fischer and Ravizza, *Responsibility and Control*, 238.
[105] Glannon, "Obsessions, Compulsions, and Free Will," 334.
[106] Recall also that 'taking responsibility' is shorthand for, roughly, 'taking responsibility for acting from one's own reason-responsive mechanism of action'.
[107] Fischer and Ravizza, *Responsibility and Control*, 238.

responsibility,' we should ask whether persons with OCD can be said to 'take responsibility' for their apparently compulsive behavior/rituals.

The impact that certain belief domains have on the experience of agency in OCD - in particular, inflated responsibility for harm and threat estimation - have tended to be neglected in philosophical treatments of the disorder.[108] The domain of inflated responsibility concerns beliefs that the agent is particularly important in preventing dangerous, harmful, or otherwise undesirable events from occurring (either through action or omission).[109] Earlier, in Flynn's recounting of her post-partum themed OCD, her fears about her infant suddenly dying, or of her suddenly 'losing control' and harming her own child, are examples of inflated beliefs about one's responsibility for harm.

Flynn's experience is just one of many potential manifestations. Dr. S narrates an attack of hit-and-run themed OCD in which he is tormented by the idea that he has struck and hurt/killed someone when he has not. He writes:

> I start ruminating, 'Maybe I did hit someone and didn't realize it...Oh my God! I might have killed somebody! I have to go back and check.' Checking is the only way to calm the anxiety. It brings me closer to truth somehow. I can't live with the thought that I actually may have killed someone - I have to check it out.[110]

J.J. Keeler describes similar fears of responsibility for deadly collisions in her memoir *I Hardly Ever Wash My Hands*, which lead her to drastically change her driving habits, eschewing the highway for safer side-streets and driving the minimum speed limit on the

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[108] Steketee, Frost, and Cohen, "Beliefs in Obsessive-Compulsive Disorder," 526–28; Sookman and Pinard, "Overestimation of Threat and Intolerance of Uncertainty in Obsessive Compulsive Disorder," 64–67.
[109] Frost and Steketee, *Cognitive Approaches to Obsessions and Compulsions*, 7.
[110] Rapoport, *The Boy Who Couldn't Stop Washing*, 23–24.

highway.[111] These exaggerated beliefs about their responsibility for causing harm in the world, and their overestimation of the likelihood of harm arising, suggest that at least some people with OCD consider themselves causally efficacious agents in the world (especially with regard to causing harm and being responsible for it). This suggests that at least some people with OCD fulfill the first requirement of 'taking responsibility'. But what about the belief that one is sometimes the appropriate target for the reactive attitudes?

Dr. S's recollection of the guilt that plagues him during his OCD attack is centered on the moral wrong of having harmed someone and/or failing to render aid, but many of his fears are also related to the ramifications and implications if such a harm did occur. For example, he writes, "I pray this outrageous act of negligence never happened. My fantasies run wild. I desperately hope the jury will be merciful. I'm particularly concerned about whether my parents will be understanding. After all, I'm not a criminal."[112]When approached by a police officer as he scours the roadside for a body, Dr. S considers that the officer is there to arrest him, and perhaps has followed him back to the scene of the collision as well. While Dr. S is unsure if the collision did occur, he seems to default to expecting that others hold him responsible for the consequences of his actions.

In Dr. S's example, we can see strong evidence that he holds beliefs (1) and (2). His worries concerning the imagined hit-and-run are about his being held responsible for

[111] Keeler, *I Hardly Ever Wash My Hands: The Other Side of OCD*, 85–100.
[112] Rapoport, *The Boy Who Couldn't Stop Washing*, 23–27.

the death of another, his being found guilty in a court of law, and so on, revealing that he considers himself to be an agent in the world whose behavior is sometimes cause for blame. Dr. S appears to have come about having these beliefs in the ordinary way. After all, his belief that he would be responsible for the death of a struck pedestrian is a true belief and one he reflects upon in the midst of his obsession. We can also see this reflected in his striving for certainty as he engages in checking rituals. Dr. S's beliefs about his own agency and potential for being held responsible are partly what drive him (at least in his mind) to search for certainty. Furthermore, if Dr. S did not consider himself an effective agent in the world or did not consider himself subject to the reactive attitudes of others or himself, it is doubtful that he would seek reassurance or engage in checking behavior (provided that the cognitive model of OCD is generally correct).

While Dr. S's worry, fleeing the scene of a fatal collision, is one that any reasonable person who took themselves to have sufficient evidence would have, this is not always so. One related element of the disorder we must consider is that persons with OCD often judge themselves to be responsible for imagined harms or 'harms' for which few 'ordinary' folks would be inclined to hold others responsible. Often these symptoms of inflated responsibility for harm are intertwined with perfectionism and purity.[113]

[113] Some persons with OCD avoid viewing non-sexual nudity, even their own body, for fear of sin or mental contamination. This can also be trigged by washing one's privates or thinking about washing these areas. Some persons with OCD will repeatedly check written correspondences (emails, letters, personal papers) for instances of unwittingly writing a racial slur, an inappropriate term, etc. even when these are not terms the person ever utilizes. Of course, writing slurs and inappropriate words is something ordinary folks avoid and would be concerned about, but is not the sort of thing ordinary folks who do not use these terms would worry about for sustained periods.

Despite these noticeable differences from ordinary folks in the population, it does not appear that Dr. S's beliefs about his own responsibility and agency are formed in an illicit way. Merely because Dr. S may believe himself to be responsible for something others would not hold him responsible for does not mean that he has not formed the relevant beliefs based on evidence available to him.

Even if we consider a slightly different wording of this final requirement of 'taking responsibility,' perhaps changing it such that that one's beliefs about one's own agency must be minimally grounded in reality, most persons with OCD still meet this requirement. Examples of what would not be minimally grounded in reality would be ones featuring extremely poor or absent insight bordering on delusional beliefs. Other examples might also concern fanciful contexts in which the agent feels compelled to complete rituals to ward off events that are imagined or impossible. Such cases notwithstanding, following from the above analysis, we can conclude that within a semicompatibilist framework, at least some persons with OCD fulfill the requirements for 'taking responsibility.'

6. Compulsion, Blameworthiness, and Difficulty

In the foregoing sections, I have argued that fundamental misunderstandings in the literature about both the nature of OCD as well as the requirements for F&R's view have skewed discussions about compulsion, freedom, and responsibility. I have endeavored to show that many manifestations of OCD have significant cognitive and epistemic dimensions which interact crucially with the features of F&R's view. This has revealed that persons with OCD are not just capable of weak reactivity, but they are also

overly-receptive to reasons for action that other agents do not perceive, and in a way that is often intelligible in the manner the theory requires. Finally, many people with OCD tend to view themselves are especially responsible for preventing harm and particularly guilty of failing to do so. These dispositions imply that persons with OCD do conceive of themselves as effective agents in the world, and ones who at least sometimes are the appropriate target of blame. Finally, while the perceptions and beliefs of persons with OCD are dysfunctional in the ways outlined earlier, their beliefs about their own agency are indeed formed based on evidence available to them (as opposed to being implanted, etc.). All of these threads lead to a new question for philosophy of agency: How does reason-responsive responsibility conceive of agents who are receptive to reasons to such a degree that it negatively impacts their agency?

One potential response from semicompatibilists is to stick with the defense that Fischer provides against Mele's example of Fred, the man with agoraphobia who can leave his home if it is aflame but not to attend his daughter's wedding. Fischer concedes there that Fred *does* possess guidance control - but that it is unlikely people would blame Fred, or at least not blame him very much:

> Fred, as opposed to the others, is morally responsible, on our approach. But it does *not* follow that he is (say) blameworthy for staying inside and not going to his daughter's wedding. This is a separate judgment, one we would not be inclined to make, given Mele's description. [...] Indeed, we would suggest that the fact that the sort of incentive needed to cause Fred's 'heroic' efforts to attend his daughter's wedding is so drastic can help to structure a more nuanced development of a theory of blameworthiness. In general, careful attention to reasons-receptivity and reasons-reactivity profiles might usefully structure our understanding of praiseworthiness, blameworthiness, and the appropriate conditions of application of the reactive attitudes.[114]

[114] Fischer and Ravizza, "Replies," 472.

This conclusion regarding Fred and those just like him is driven by the fact that Fischer & Ravizza are careful to frame having the capacity for guidance control as being an *apt* target of blame - which is to say that blame would be permissible but not required.[115] Fischer considers it metaphysically perspicacious to be able to distinguish between agents who are morally responsible and also blameworthy, agents who are morally responsible and not blameworthy, and agents who are neither morally responsible nor blameworthy.

Two prominent and distinct issues arise when we consider this response. The first is the familiar question about the relationship between compulsion, freedom, and responsibility. For, it is a problem for our conceptual tidiness and coherency if compulsive action and free action ever overlap, and this particular conceptual issue has a storied history in agency theory. The second distinct issue that arises is in the context of the relationship between compulsion, responsibility, and blameworthiness. Often what appears to at least partly motivate our intuitions about the incompatibility of compulsion and freedom is that unfree actions, all things being equal, make us ineligible for being held responsible for those actions and their consequences.

What we need, then, is an explanation of how it is that compulsion exempts an agent from blame. In his reply to Mele, Fischer only hints at the suggestion that the effort required by Fred is instructive of how theorists can better build a Strawsonian framework of blameworthiness. This would be a theory that is able to explain why we would not

[115] Fischer and Ravizza, *Responsibility and Control*, 8; Fischer and Ravizza, "Replies," 471.

blame someone like Fred despite his having the capacity for guidance control and thus being an otherwise apt target for the reactive attitudes. In correspondence, Fischer has suggested that judgments about blameworthiness are at least partially conditioned on the level of difficulty an agent has in reacting to relevant good reasons for action in the actual sequence. In cases like Fred's, the difficulty in responding to the reason for leaving his house provided by his daughter's wedding makes it unreasonable to expect Fred to respond to that reason / resist his contrary impulses or desires.[116]

This is not dissimilar to other approaches to delineating the difference between compulsion and, say, weakness of will (which is free and responsible action). Gary Watson has suggested what I will term the *counterfactual resistance* view. On this view, a person's behavior is compelled to the extent that other agents find it unreasonable to expect that agent to have developed the capacity to resist acting on the root desire, impulse, etc. of that action. Note that, on Watson's formulation, there is a significant role played by the community in articulating whether an expectation is reasonable.[117] Watson's counterfactual resistance view has been further developed by Michael Smith, who focuses on a possible-worlds analysis of difficulty.[118]

Problematically for semicompatibilists, this particular analysis of resistance or difficulty is not available. To achieve everything Fischer & Ravizza want out of a theory of responsibility, they settle upon an *actual sequence theory*. That is, F&R's view analyzes control and responsibility only by reference to the actual sequence of events as

[116] John Fischer, email to author, March 23, 2021.
[117] Watson, *Agency and Answerability*, 72–73.
[118] Smith, "Rational Capacities, Or."

opposed to referencing alternate possibilities. While F&R's view is able to artfully avoid alternate possibilities with respect to determining if some mechanism is sufficiently reason-responsive, I doubt this same approach can be applied to difficulty. This is because F&R make use of 'dispositional' or 'modal' properties of the mechanism of action which, they contend, licenses them to reference possible worlds without asserting alternate possibilities that are accessible to the agent.[119] A mechanism being weakly reactive just tells us that the mechanism is able to react to relevant reasons for action. It does not tell us to the relative difficulty in responding to certain reasons or types of reasons over others. Recently Coates and Swenson depart from this semicompatibilist line and argue that moral responsibility is scalar rather than binary. They appeal to relative accessibility of possible worlds in analyzing reasons-reactivity and the 'difficulty' in doing so, and the intelligibility of an agent's pattern of reason-recognition for reasons-receptivity.[120]

What our earlier analysis of OCD reveals is that our conception of 'difficulty' needs to concern more than just reason-reactivity. This is because compulsive rituals in OCD primarily concern the person's recognition of reasons and considerations for and

[119] Fischer and Ravizza, *Responsibility and Control*, 53.

[120] For their part, the degree of reactivity an agent possesses is measured based on the nearest possible world in which the agent *is* reactive to a sufficient reason to act. The degree of receptivity an agent displays an intelligible pattern of reason-recognition will be the degree to which that agent is reason-receptive. Interestingly, the driving example of Coates & Swenson's paper is a marginal case in which a friend, who has major depression, fails to pick you up from the airport due in part to the symptoms of her disorder. This use of marginal cases is not problematic, chiefly because Coates & Swenson are seeking to examine our blaming practices through the lens of a common social interaction and common disorder. The example of Marcia is not framed as a counterexample to a theory, but rather a phenomenon that we would like to be able to explain and capture with our philosophical theories.

against repetitive rituals which are skewed by dysfunctional beliefs and perceptions about risk and harm. We must move past the idea that compulsion is (or is *only*) a failure to *react* to reasons appropriately and develop a story about how the sort of difficulty people with OCD face is bound up in their struggle with uncertainty in the face of mounting apparent reasons for compulsive rituals.

A starting place for this sort of account of difficulty is to look to the agent's ability to challenge their dysfunctional beliefs in the moment of deliberation. Challenging a maladaptive belief is an element of different types of cognitive behavioral therapy and is often targeted toward reducing the strength or impact of this belief on the person's behavior. Challenging perfectionist beliefs can mean reframing the thought so that 'Making a mistake is as bad as failing completely' becomes something like 'Making mistakes helps me overcome my fears'. Here, reframing the belief recasts the 'wrong' as an opportunity for growth. Challenging beliefs can also take the form of practicing tolerating negative emotions and sitting with uncertainty. For example, one might challenge the belief 'If I don't do a perfect job, no one will respect me' by sitting with the negative feeling of guilt or inadequacy in order to decouple the feeling from the belief.[121]

Developing a conception of difficulty that explains how people with OCD are exempted from blame despite being labeled morally responsible must make reference to the dysfunctional beliefs in the disorder that lead to over-receptivity of reasons. If an agent is unable to challenge these beliefs and reject (or lessen the weight of) the reasons

[121] Roncero, Belloch, and Doron, "A Novel Approach to Challenging OCD Related Beliefs Using a Mobile-App," 157-8.

these beliefs present to her, we seem licensed say that she is exempted from blame due to unreasonable difficulty. What must yet be developed is a description of how we determine what is or is not reasonable to expect an agent to overcome with respect to reason-responsivity.

7. Conclusion

I have argued that a proper understanding of both OCD as well as the requirements of reason-responsive responsibility yields a novel question for moral responsibility: how are we to conceive of agents who are overly reason-receptive (as opposed to insufficiently reason-reactive)? F&R's view, due to its various commitments, may be wedded to saying that many people with OCD are morally responsible but not fully blameworthy (or are exempted from blame) due to the difficulty these agents have in responding to sufficient reasons for action. However, this raises the question of how we should understand 'difficulty' in light of the nature of OCD. I suggest that the beginning of this kind of account of difficulty lies in the relative ease with which a person with OCD challenges the dysfunctional beliefs that underlie or support her obsessions and compulsions. Such an account would cohere with our present understanding of the way insight impacts the severity of OCD symptoms.

As outlined in the first chapter, insight is an oft overlooked diagnostic feature of OCD, and one which has significant philosophical implications. In the next chapter, we will look specifically at cases of low or absent insight in OCD. While these cases are in the minority, they also represent some of the most ill patients with the disorder. In moral psychology, obsessions have been cast as external to the agent experiencing them and

contrary to what the agent herself values. Yet, in low insight cases, the obsessions these agents experience appear to mirror the agential capacity of caring which has strong connections to internality. We will examine this relationship between obsessions and caring, ultimately finding that low insight OCD manifests as the agent caring about the object of their obsession. This helps us understand the intransigence of low insight cases as well as the puzzling behavior of these agents in comparison to those with fair or good insight.

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Chapter 3: Obsessions, Over-valued Ideas, and Internality

> Turning one's mind in a certain direction, or deliberating systematically about a problem, are activities in which a person himself engages. But to some of the thoughts that occur in our minds, as to some of the events in our bodies, we are mere passive bystanders. Thus there are obsessional thoughts, whose provenances may be obscure and of which we cannot rid ourselves; thoughts that strike us unexpectedly out of the blue; and thoughts that run willy-nilly through our heads.
>
> Harry Frankfurt, "Identification and Externality"[122]

Obsessions typically feel as though they beset us rather than originate from us, and as such are often unwelcome guests in our minds. Many agency theorists, like Harry Frankfurt, Michael Bratman, and Agnieszka Jaworska explicitly endorse this external view of obsessions.[123] As Frankfurt describes in the passage above, obsessions are an example of a 'movement of our mind' from which we typically feel alienated. Alternately, some of these same theorists hold that our *cares* are often considered internal to us. For example, Frankfurt has argued that we can identify with our cares, both in our vulnerability to how the object of care is faring and our second-order cares *about* our cares, thus helping to structure our lives.[124] Agnieszka Jaworska holds that our cares are internal in that they help unite our temporally extended agency, even if we lack the ability to reflect upon or form evaluative judgments about our cares.[125] Furthermore, although on her view we might be tempted to consider obsessions as "exemplars of caring,"

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[122] Frankfurt, "Identification and Externality," 59. I borrow Frankfurt's somewhat poetic description of being 'beset' by these external thoughts.
[123]Frankfurt, "Identification and Externality," 59; Bratman, "Planning Agency, Autonomous Agency," 198; Jaworska, "Caring and Internality," 593, fn. 97; Schroeder and Arpaly, "Alienation and Externality," 384, fn. 23.
[124] Frankfurt, "The Importance of What We Care About," 260-265.
[125] Jaworska, "Caring and Internality," 568.

Jaworska's account vindicates the commonsense view of obsessions as "quintessentially external" to the agent.[126]

Yet, as I will argue here, a subset of obsessive-compulsive disorder (OCD) cases fit Jaworska's criteria for caring and are thus internal to the agent experiencing them. A proper understanding of these clinical obsessions reveals that they can play a structuring role in an agent's life and self-conception of herself over time. In certain severe cases of OCD, the beliefs that underlie a person's compulsions are strongly endorsed as true. Those suffering from such severe OCD often order their lives around their obsessions and around ensuring their compulsive behaviors are 'effective.' This suggests obsessions are not necessarily external to the agents suffering from them, and qualify as carings.[127] This runs contrary to the received view of obsessions as prototypically external mental phenomena and would appear to render Jaworska's theory of caring and internality too permissive.

My argument need not serve as a fatal counterexample to Jaworska's theory. Instead, I propose that we can better understand such obsessions when we see them as *disordered caring*. Those with clinical obsessions often overvalue the importance of the object of care in the scheme of their ends and values, or misperceive what circumstances contribute, or are deleterious, to the flourishing of the object of care. Treating clinical obsessions as disordered caring may also allow us to create a conceptual framework in

[126] Jaworska, "Caring and Internality," 563.
[127] As I note later, obsessions can often be classified as *ego dystonic* which carries the deep connotation that it is contrary to the agent's wishes or desired sense of self. However, that the content of an obsession is distressing or perhaps in conflict with other cares or held values is not itself a disqualification from internality in the sense important here.

psychology for understanding the related but undertheorized phenomenon of over-valued ideas.

I begin by briefly outlining Agnieszka Jaworska's theory of caring and internality, along with her characterization of clinical obsessions as delimiting her theory of caring and internality. From there, I contrast Jaworska's characterization of clinical obsessions with one that is more sensitive to the diagnostic criterion of *insight* that a person with OCD displays into the reasonableness of their beliefs. I show that those with OCD who demonstrate poor insight in fact meet all of Jaworska's criteria for caring about the 'object' of their obsessions, making their obsessions internal to them. I then turn to a relevant manuscript of Jaworska's where she proposes an additional criterion of caring in order to explain how the obsessive interests of some dementia patients are not internal to them. Yet, even with the additional requirement that an apt object of care must have an independent standard of flourishing, many clinical obsessions will still meet Jaworska's criteria for caring. Finally, I argue that labeling such obsessions as cares allows us to theorize about 'disordered caring' which can provide a conceptual framework for understanding the concept of *over-valued ideas* used in psychology.

1. Caring and Obsessions

Agnieszka Jaworska argues that caring consists of "a set of interrelated emotional, motivational, cognitive, and deliberative dispositions that focus on a particular object" which she also describes as "a structural compound of various less complex emotions, emotional predispositions, and also desires, unfolding reliably over time in response to

relevant circumstances."[128] We can thus identify four prominent features of caring on this theory: (1) emotional dispositions or vulnerability to the way the object of care fares, (2) rational pressure for our emotional dispositions to conform to one another, (3) temporal extension such that caring does not arise or disappear quickly, and (4) the role of our cares in helping structure our agency over time, featuring into planning, intentions, and so on.

Emotional vulnerability entails being disposed to have properly-valenced emotional reactions to how the object of care is faring – worry when it is endangered, happiness when it is doing well, etc.[129] These dispositions are object-oriented in that they track the welfare of the object of care. This involves, among other things, rational pressure for the agent's reactions and dispositions to conform with one another: "If things go well for the object of care, fear or hope are rationally required to turn into an emotion such as relief, and when things go badly, frustration or disappointment are rationally called for."[130] This also implies that carings must be relatively stable in the face of conflicting impulses, desires, or interests. Additionally, caring is not the sort of attitude that can arise immediately or disappear quickly - it takes time to wax and wane. Finally, our cares form a sort of scaffolding for our diachronic agency and help structure intentional action and planning.[131]

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[128] Jaworska, "Frontotemporal Dementia and the Capacity to Care," MS 1. See also Jaworska, "Caring and Internality," 560.
[129] Jaworska, "Frontotemporal Dementia and the Capacity to Care," MS pg 1,
[130] Jaworska, "Caring and Internality," 561.
[131] Jaworska, "Caring and Internality," 561-2.

A core feature of cares on Jaworska's view is that they are invariably *internal*. Internality represents what an agent does in fact stand for regardless of her knowledge or feelings about it, whereas subjective identification is what an agent stands for explicitly and consciously.[132] Following Bratman, Jaworska holds that attitudes that speak for an agent must play some role in supporting or partially constituting the agent's diachronic agency, but contra Bratman, without the requirement that these must be attitudes about other attitudes (reflexivity):

> The resulting, more permissive account of internality is this: *any attitude, reflexive or not, has the right kind of authority to speak for the agent, so long as it is part of its function to support the psychological continuities and connections that constitute the agent's identity and cohesion over time.*[133]

Caring is thus an emotional attitude an agent can have that need not be reflexive or based on judgments concerning other attitudes but must be one that can contribute to uniting an agent's identity over time.[134]

In a footnote Jaworska worries readers may find her view to be overly permissive, as it may allow obsessions to be internal rather than external (as they are commonly thought to be). The case of clinical obsessions is most pertinent:

> Part of the problem is that the term 'obsession' encompasses two sorts of rather different phenomena. On one side, there are obsessions familiar from the obsessive-compulsive disorder: a woman obsessed with cleanliness washes everything in sight several times a day; she fears things left unwashed, she is temporarily relieved after washing them, etc. But, crucially, she doesn't believe those things are dirty. She is baffled by her own reactions: her emotional view of the world as dirty is at odds with what she believes based on available evidence. So she herself does not see her emotional reactions as appropriate responses to her own understanding of

[132] Jaworska, "Caring and Internality," 531; 537-8.
[133] Jaworska, "Caring and Internality," 552. Emphasis original.
[134] Jaworska, "Caring and Internality," 559.

> the situation. Obsessions of this sort seem obviously external, but this is because they impose an emotional view of factual matters that contradicts the person's reasonable beliefs, alienating the person from her own reasoning. On my account, such bizarre emotions would indeed be external: due to the factual distortions, the agent would not view the focus of her emotions as important, so she would not structure her plans and intentions to promote it; it would not then function to unify her agency.[135]

The potential worry is that if cares are invariably internal, and obsessions are paradigmatically external but exemplars of caring nevertheless, then the proposed theory of caring may be too permissive. This would be because it allows a prototypically external mental phenomenon like obsessions to be considered internal to a person.[136]

In her example, Jaworska describes a person afflicted with OCD as (1) not believing the content of her obsessional thoughts, (2) consequently not believing her emotional reactions to dirt and contamination are appropriate, (3) viewing her emotional attitudes toward the object of her obsession (cleanliness) as external and thus being alienated from them, (4) not construing the object of her obsession and the performance of compulsions as important, and finally (5) not structuring her life in the form of planning and intentions to promote the content of her obsessions. On this basis she concludes that these clinical obsessions do not count as caring and do not themselves make her theory problematically inclusive. In the following section I outline clinical obsessions within OCD with an

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[135] Jaworska, "Caring and Internality," 563 fn. 97. Bold emphasis added.

[136] Jaworska also discusses the example of Humbert Humbert's obsession with Lolita in Nabokov's novel, concluding that her view would say that Humbert cares about Lolita. While I am primarily concerned with clinical obsessions within OCD and related disorders, Troy Jollimore has suggested to me that Jaworska's comments on this case, paired with the ambiguity of what counts as an obsession simpliciter, calls for a clearer conceptual analysis of obsessions. I agree with this assessment, although creating a univocal understanding of obsessions is not my present goal.

emphasis on the diagnostic criterion of insight. This reveals that there is a subset of OCD cases that do in fact count as carings.

2. Insight in OCD

One particular diagnostic criterion of OCD involves specifying the degree of insight a person demonstrates into the nature or veracity of their beliefs about their obsessions and compulsions. We previously discussed this in Chapter 1 as an oft-forgotten feature of the disorder. To recap, as the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (DSM V) describes it:

> **With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
> **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.
> **With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.[137]

The vast majority of those suffering from OCD have good to fair insight, recognizing that their beliefs concerning their obsessions and compulsions are probably not accurately tracking the way the world is.[138] In this regard, I would say that Jaworska's description would plausibly cover a significant portion of OCD cases.

However, a minority subset, arguably those suffering most severely from OCD, have poor or absent insight bordering on delusional beliefs:

> Individuals with OCD vary in the degree of insight they have about the accuracy of the beliefs that underlie their obsessive-compulsive symptoms. […] Some have *poor insight* (e.g., the individual believes that the house will probably burn down if the stove is not checked 30 times), and a few (4% or

[137] DSM V, 237 (emphasis original).
[138] Remember: we are currently agnostic about the philosophical nature of the 'beliefs' in OCD. We continue this investigation in chapter 4.

> less) have *absent insight/delusional beliefs* (e.g., the individual is convinced that the house will burn down if the stove is not checked 30 times).[139]

In these more severe cases, we find a clinically significant portion of OCD patients who fulfill the criteria for caring.

Let's consider the fictional case of Maggie, a person suffering from contamination-focused obsessions and compulsions just like in Jaworska's original example. Maggie's case, however, is adapted using features from a recent study concerning delusional beliefs in OCD:

> **Maggie** suffers from OCD with poor insight bordering on delusional beliefs. She fears that she and those around her will contract HIV if she does not take precautions to protect them. She believes it is easy to contract or spread HIV through contact with bodily fluids like mucus, feces, saliva, urine, blood, etc. To keep herself and others safe, Maggie engages in elaborate washing and cleaning routines of her body and frequently-touched surfaces.
>
> Maggie's cleaning (showering, hand-washing, disinfecting, scrubbing) and ruminating about contamination take hours per day nearly every day. She has been late to work and social gatherings due to her washing and fear of infecting herself or others. Maggie often tries to plan for her cleaning routine, waking up earlier for work to compensate for the time it takes to perform her washing. At other times, Maggie intentionally sits out of plans with friends to have time to properly perform her rituals. She will avoid using public restrooms even at great discomfort and avoids excessive travel from her home and crowded areas like airports and supermarkets.
>
> Maggie takes protecting herself and her family from HIV infection seriously and becomes distressed and fearful when she is unable to wash or feels she has not washed correctly. When she feels properly clean, she experiences temporary relief. Most of the time, Maggie strongly believes she and others are at risk of HIV infection in typical circumstances, and further believes their health and safety depend upon her cleanliness.[140]

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[139] DSM V, 238, emphasis original.

[140] The example of Maggie is a composite that is heavily adapted from Case #3 in Anne-Marie O'Dwyer and Isaac Marks, "Obsessive-Compulsive Disorder and Delusions Revisited" in *British*

Maggie (1) believes strongly in the content of her obsession, that at various times she and/or her environment pose a threat to her health and the health of her family. Unlike in Jaworska's example, Maggie does indeed believe that the world around her is dirty. Maggie also (2) believes her family is at risk of HIV infection and that her cleansing is causally efficacious and thus in line with the way the world is. Maggie (3) does not explicitly view her obsession with the safety of her family to be external to her. That is, she is not alienated from her emotional attitudes toward the safety of her family and the dangers of HIV but rather appears to endorse them. Maggie (4) certainly judges the content of her obsessions to be important rather than frivolous or curious, and she (5) shows strong signs of structuring her life around her obsession with contamination as evidenced by the way she attempts to integrate it into her life alongside her other commitments and even allows it to trump some of her other plans or desires.

One might worry that, since clinical obsessions are typically experienced as contrary to what one values (sometimes termed ego-dystonic) then they should not be reliably internal in the way that caring requires on this view. But we can be distraught over what we care about, and we can wish that we did not care about an abusive partner or feel conflicted about our care for them. Experiencing an attitude or thought as alien to oneself is different from feeling disturbed by or conflicted due to an attitude or thought one takes to be their own.

Journal of Psychiatry 176 (2000): 282, as well as case studies from the Columbia University Department of Psychiatry. Some of these changes reflect other diagnostic criteria that can add to the severity of OCD, such as the time spent completing compulsions and experiencing obsessions, and so on.

What we learn from incorporating the diagnostic criterion of insight into our theorizing and examining the case of Maggie as an illustration is that clinical obsessions do not necessarily lack the constitutive features of caring. This calls into questions the assumption that Jaworska cites, borne out by other philosophers of agency, that obsessions are quintessentially external. It does so by suggesting that some clinical obsessions may be included under the heading of carings. This may prove beneficial to both philosophy and psychology by providing a conceptual framework for better understanding these types of obsessions. Before turning to this, it will be fruitful to consider how Jaworska might respond to the foregoing example. In a recent manuscript, she develops a new and potentially relevant criterion for caring that concerns dementia and putative objects of care.

3. Standards of Flourishing and Scrupulosity

One response to the inclusion of obsessions as cares might be that the objects of one's cares must have an independent standard of flourishing. That is, there must be some metric upon which the object can fare better or worse separate from any person's judgment or interest in that object. Would the objects of clinical obsessions lack such a standard? In a recent manuscript, Jaworska addresses a similar concern about the formation of obsessional interests in patients with the behavioral variant of frontotemporal dementia (bvFTD). Centrally, Jaworska asks whether bvFTD patients *lack the capacity to care*, using the example of Karen, a person suffering from bvFTD, as a case study. Once a loving mother and wife, Karen becomes emotionally flat and does not engage in caring behaviors toward her family or seem to acknowledge that her

behavior is upsetting and cold. However, Karen developed an intense interest in dining out constantly despite financial pressures not to.

One of Jaworska's key questions regarding Karen is whether she cares about dining out. In keeping with clinical intuitions that bvFTD results in an incapacity of caring (rather than "a disorder of one form of caring, caring about people"), Jaworska resists the idea that Karen cares about dining out, and attempts to modify her theory with the following addition.[141] An apt object of care must have some internal standard of flourishing independent of the wants of anyone in particular, and such obsessional interests are not carings because they do not concern something that can be cared about. As Rankin and Seeley illustrate, persons suffering from bvFTD can be subject to a wide range of obsessive-compulsive symptoms (OCS), *some* of which may concern potential objects of care whose internal standard of flourishing is either muddled or could plausibly exist 'objectively.'

Take, for example, bvFTD patients who become obsessed with, and compelled to collect, certain objects (e.g. three-legged stools) or catalogue items and events.[142] Do collections of this kind have an internal and independent standard of flourishing? Collections can be more or less complete depending upon the nature of the collection. They can also be properly preserved or poorly treated, and so on. But, as Jaworska considers these examples, the motivations of the patient are not focused on standards

[141] Jaworska, "Frontotemporal Dementia and the Capacity to Care," MS, 1-5; 5.
[142] See "Rankin and Seeley on Frontotemporal Dementia" at https://www.youtube.com/watch?v=eAF641fPz8g, as well as Jaworska, "Frontotemporal Dementia," 8.

relevant to either instrumental goods (e.g. collecting bottles due to a care about recycling) or the sorts of standards I have mentioned (e.g. no focus on *properly* cataloguing dead ants from the garden).

Even if the obsessional behaviors of bvFTD patients do not meet the requirement that an object of care have an objective standard of flourishing, the objects of OCD obsessions often have such a standard.[143] To use Jaworska's own example from *Caring and Internality*, contamination obsessions and attendant washing compulsions concern a standard of cleanliness or purity. Regular and thorough bathing is an important element of self-care and health, can be performed objectively better or worse, and one's grooming can fall within or short of widely agreed upon standards. When someone like Maggie scours her body repeatedly for fear she will be unclean if she does not, the problem is not that her behavior concerns an 'object' with no objective standard. Rather, she has mistaken either the import of meeting this standard, or her beliefs about what threatens or meets this standard drive her to act in self-destructive and harmful ways. The same can be said for when the content of OCD obsessions concerns the fear that one has unknowingly struck a cyclist or pedestrian and must thus retrace her route for signs of a collision or monitor the news for any hit-and-runs in that area. There is an objective and agreed upon standard for safe driving and following the rules of the road. But such a person fears their behavior has failed to meet this standard.

[143] Frankfurt gestures at the idea that objects of care can be important independent of our caring about them, or in virtue of our caring about them. Thus, Jaworska's proposal is another difference between her view and Frankfurt's. See Frankfurt, "Importance," 269-272. Of particular interest is his example that a person who cares about avoiding stepping on cracks in a walkway is in error (271).

Another particularly relevant variant of OCD obsessions has garnered attention from philosophers working on moral responsibility as well.[144] *Scrupulosity* concerns an obsession or fear that one has or will act immorally, wickedly, and so on, as well as intrusive thoughts or images thought to be sinful or blasphemous. To be worried that one's fate in the afterlife is compromised by what one takes to be her own blasphemous mind is to demonstrate concern about one's moral standing. To confess, beg forgiveness, and repeatedly pray is to attempt to better one's moral standing.[145]

While in Maggie's case, in most instances of scrupulosity, and in some other manifestations of OCD there is an object of care at the center of the obsession that plausibly has its own standard of flourishing, this does not hold universally. OCD has varied obsessional content and a spectrum of subtypes. Due to this variation, claims that the object of obsessions has an independent standard of flourishing are conditional and will not hold for *all* clinical obsessions. An obsession that one has a certain sexual orientation does not admit of an independent standard. That a word, gesture, or action need be repeated a certain number of times or be performed 'just so' is a subjective, rather than objective, determination. Nevertheless, the foregoing shows that a clinically

[144] See Pickard, "Scrupulosity and the Shady Morality of Psychiatry," Summers, and Sinnott-Armstrong. "Scrupulous Agents," and Schroeder, "Obsessive-Compulsive Disorder and Moral Agency," for more on the ways that Scrupulosity has been considered philosophically (usually in connection with questions about responsibility).

[145] Here we see that scrupulosity concerns morality, and though we may not want to endorse moral realism or divine command theory, there are strong intuitions that morality or moral behavior has a standard of flourishing else no one can care about it, and thus ought to be included as a possible object of care.

significant subset of those with OCD can plausibly be said to care about the object of their obsessions, and care in a way that is internal to them in the philosophical sense.

4. Disordered Caring

At least some obsessions, when severe and lacking significant insight on the part of the patient, count as caring on Jaworska's model. Furthermore, in many such cases we see that the defect in obsessions need not concern an object that is idiosyncratic in its importance or standard of flourishing. Even though these obsessions count as caring, how can we diagnose what has gone awry? In what follows I will develop the concept of *disordered caring* and suggest that it can serve as a conceptual framework for an undertheorized notion in psychology, the notion of *over-valued ideas*. Utilizing disordered caring to better understand over-valued ideas will help open new approaches to treatment. I focus on over-valued ideas and disordered caring in the context of OCD, but I suspect only minor alteration would be required to fit the framework of disordered caring to other cases of over-valued ideas, like body dysmorphic disorder.

Since we have shown that Maggie and others like her care about the object of their obsessions, we need now outline what is disordered about this caring.[146] When we look at the way in which Maggie attends to cleanliness and contamination and incorporates her rituals into her life, we can generate a list of ways in which her caring may be considered disordered.

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[146] Here I use the term 'disorder' very generally and without much sensitivity to nosological distinctions. We can consider 'disordered' here to mean maladaptive. I also do not mean for 'disordered caring' to imply that the caring is itself disordered. Instead, disordered caring involves primarily epistemic faults that merge with the otherwise properly-functioning system of caring in the agent's psychology.

1. Excessive concern for, or sensitivity to, factors thought to contribute to or be deleterious to the flourishing of the object of care;
2. Mistaken judgement(s) about the standard of flourishing of the object of care, especially with regard to the extent or degree of that standard;
3. Harmful overvaluation of the object of care relative to other held commitments (including values, other cares, and so on).

Recall, Maggie is markedly more attentive to what she takes to be contaminated or unclean than a person with a typical concern for hygiene. Connected to this is her stringent standard of cleanliness that is not only beyond what is typically required but to the point that it is harmful to Maggie, her body, her relationships, and so on. Finally, Maggie makes room for her compulsions and ruminations in her life and in ways that hinder other interests she has, cause disruptions in her relationships and work life, etc.

Concerning (1) above, this is a perceptual and epistemic error that roughly tracks what is known in psychology as *overestimation of threats.* Overestimation of threat is thought to connect with "beliefs about the likelihood or probability of aversive events, and their severity and consequences" that may also connect with certain faulty information processing, such as "assuming from feelings of anxiety that danger is present."[147] On at least one conceptualization and treatment model for OCD, overestimation of threat in part characterizes the dysfunction in the suite of "core beliefs about danger, with emotional, interpersonal, and behavioral aspects" that arise from

[147] Sookman and Pinard, "Overestimation of Threat and Intolerance of Uncertainty in Obsessive Compulsive Disorder," 65, 66.

formative experiences. These can concern perceived internal or external threats (e.g. intrusive thoughts vs. illness or accident).[148] Maggie from our earlier example displays an overestimation of threat when she overestimates the communicability of HIV, or the level of risk that she and her family are exposed to under particular circumstances.[149] Earlier, in Chapter 2, we looked at the ways in which these dysfunctional patterns of 'belief' strongly influence what reasons the agent perceives for action, acting as a kind of filter or lens through which the agent evaluates courses of action.

The remaining points, (2) and (3), relate to an under-researched concept in psychology known as *over-valued ideas*. While there is no explicit/full agreement about the exact features of an over-valued idea, it is another term sometimes used when a patient lacks insight in the diagnostic sense outlined earlier (largely endorsing the beliefs that underlie her obsessions and compulsions). According to D. Veale, how to understand and treat over-valued ideas is underexplored in psychology.[150] Over-valued ideas are recalcitrant to many treatment options and so a better conceptual understanding of the phenomenon will assist in crafting treatment options for those suffering from over-valued ideas within OCD and within other disorders.

Veale offers his own conceptual framework that tries to incorporate both normative and epistemic dimensions since he says that "the *values* that exist in an abnormal mental state are not usually described in psychopathology or cognitive theories

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[148] Sookman and Pinard, "Overestimation of Threat," 67.
[149] It may also be appropriate to say that Maggie overestimates the efficacy of her rituals or underestimates the effectiveness of basic hygiene practices.
[150] Veale sometimes uses 'obsessions' as distinct from over-valued ideas but elsewhere it is clear over-valued ideas are present in OCD. Cf. Veale, 384, 390.

but are related to evaluations."[151] Since caring is a complex emotional attitude that involves these dimensions and others that have previously been associated with over-valued ideas, disordered caring can serve as a scaffolding for understanding this phenomenon. In this way, I hope that the idea of disordered caring can contribute to our philosophical and clinical understanding of obsessions in a way that might prove useful for crafting treatment options. Before turning to treatment possibilities, I would like to highlight the ways in which the various cases I have outlined connect with the features of over-valued ideas in the psychology literature. This will establish that the concept of disordered caring has explanatory power to help better understand over-valued ideas.

According to Veale the term 'over-valued idea' has become shorthand to refer to "*poor insight* in the middle of a continuum of obsessional doubts to delusional certainty" with obsessional doubt/good insight on one end, and delusion/absent insight on the other.[152] The DSM-V defines an over-valued idea as "An unreasonable and sustained belief that is maintained with less than delusional intensity (i.e., the person is able to acknowledge the possibility that the belief may not be true). The belief is not one that is ordinarily accepted by other members of the person's culture or subculture."[153] The DSM-V does not explicitly draw a connection between poor insight in OCD and over-valued ideas, but we can see how the criterion for poor insight (that "The individual thinks obsessive-compulsive disorder beliefs are probably true"[154]) is consistent with a sustained

[151] Veale, "Over-valued ideas," 388.
[152] Veale, D. "Over-valued Ideas: A Conceptual Analysis," 384-5.
[153] DSM-V, 826.
[154] DSM-V, 237.

obsession. We need not accept the view that overvalued ideas occupy the middle ground between good and fair insight in order to appreciate Veale's suggestion that overvalued ideas occur within the spectrum of insight.

But there is also a broader sense of an over-valued idea present previously in European psychology. Veale identifies a number of these features across a number of publications into the mid-1980's. Many of these features easily describe Maggie's case and others. I note below some of the most salient features of this older conception of an over-valued idea:

> a. Is held strongly, with less than delusional intensity.
> b. Usually *preoccupies* the individual's mental life, compared to many delusions.
> c. Is ego-syntonic, compared to most obsessions. […]
> f. The content is usually regarded as abnormal compared to the general population (but not bizarre as some delusions).
> g. Causes disturbed functioning or distress to the patient and others.
> h. Is associated with a *high degree of affect* (e.g. anxiety or anger when there is a threat to the loss of their goal or object of the belief).
> i. Compared to many delusions, is more likely to *lead to repeated action* which is considered as justified. […]
> l. Have some similarities to passionate religious or political convictions where the individual usually remains functional.[155]

Note how (l) draws explicit comparison to passionate conviction which is a not-uncommon assessment of those with scrupulosity. (i) indicates those with over-valued ideas may be more inclined to repeated action they consider justified on the basis of that over-valued idea, as with Maggie's washing rituals, which she sees as justified by her persistent beliefs about the world. (b) and (c) provide indications that an over-valued idea is not distressing in the same way that an ego-dystonic obsession or intrusive thought

[155] Veale, "Over-valued Ideas," 385. Emphasis original.

would be. We can even see how the properly-valenced reactions one has to objects of care (e.g., fear when it is endangered) are consistent with the high degree of affect mentioned in (h). For example, if the threat of HIV was truly at the level Maggie believed it to be, then her responses would be reasonable or justified. However, since the primary deficits of disordered caring are epistemic, this is where we see the majority of dysfunction.

Another important feature of over-valued ideas that connects strongly with my claim that severe obsessions are a form of disordered caring is "the excessive identification of the [object/value] with the self or the 'personal domain'".[156] This relates to a feature of Jaworska's theory of caring discussed earlier, viz. that if obsessions are cares then they must be internal to the agent experiencing them, speaking for her in an important way and playing a role in structuring her diachronic agency. Internality can capture this sense in which an agent with an over-valued idea, like Maggie, incorporates the content of her obsession into every aspect of her life and often gives it pride of place among the other things she values.[157]

Disordered caring allows us to better understand overvalued ideas because it provides an explanation for the various features of overvalued ideas: the agent cares, but in a way that is warped by perceptual, epistemic, and normative errors. I think it also provides a ready explanation for why overvalued ideas are particularly recalcitrant to

[156] Veale, 388.
[157] I think it can also capture other extreme examples outside of OCD, like the example Veale gives of the patient with chronic anorexia nervosa defining her identity in terms of anorexia (389).

treatment: as cares, these obsessions have developed over time and involve a complex emotional attitude that goes beyond a mere cognitive belief or desire such that they have wheedled their way deep into the agent's identity and foundational structures of agency (like their plans, intentions, and so on). It is for this reason that I think a suggestion by Mark Rego holds promise for treatment, with proper alterations made.

Rego uses Frankfurt's early work on identification and externality to suggest a model of psychodynamic treatment built around forming a narrative that externalizes the problem the patient faces.[158] One difference, of course, is that on Frankfurt's model of identification that Rego uses, it is the patient's explicit decision to externalize the concern (coupled with appropriate assistance from the healthcare practitioner) that does the bulk of the treatment work. Cares, on the other hand, are internal in virtue of their structure as an attitude. Additionally, many people suffering from overvalued ideas do not themselves voluntarily seek treatment. This may stem from the ego-syntonic nature of overvalued ideas paired with the inclination these agents have to see their beliefs and actions as justified.

Rego's proposed application of the concept of externality and identification in psychodynamic treatment could benefit from additional complexity to handle more nuanced mental states than those where agents are able to take directly oppositional or externalizing stances from the start. I suspect that a more effective treatment for those with overvalued ideas is to simultaneously promote the agent's other values and cares while challenging and slowly diminishing the patient's commitment to the overvalued

[158] Mark Rego, "Externality in Psychiatry and the Paradox of Agency," 313-318.

idea. This process also helps mimic the way that many agents go about assessing and weighing their values and can help these patients in particular see the impact their obsessions are having on the other areas of their life that they care about.

5. Concluding Remarks

In this chapter, I have argued for three central claims: that (1) some obsessions qualify as carings on at least one leading theory of caring, (2) not all obsessions are external to the agent experiencing them, and (3) the idea of 'disordered caring' provides a conceptual framework for advancing our understanding of *over-valued ideas* in psychology and provides a more interdisciplinary understanding of a complex and debilitating phenomenon. That some clinical obsessions are internal to the agent experiencing them is surprising, but the notion of disordered caring allows us to make sense of how it is that this obsession has become so closely intertwined with the agent's identity.

In the next and final chapter of the dissertation, we examine in detail the claims that OCD involves dysfunctional beliefs and engage with a litany of issues that emerge as a result. This involves analyzing whether OCD involves philosophical beliefs and, if so, the role these beliefs play in the maintenance and etiology of the disorder. Ultimately I conclude that we are in need of a concept distinct from extant approaches, and I offer Robert Roberts' conception of emotional construals as one potential way to fill this lacuna.

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Chapter 4: Understanding Beliefs in the Context of Obsessions and Compulsions

In previous chapters we have relied on a general understanding of the belief-like states at work in OCD, concluding that OCD involves dysfunctional beliefs that follow certain patterns and that these beliefs appear to play a significant role in the perpetuation of the disorder across different portions of a person's life. These beliefs concern not just the world around the person but also their role in the world as an agent and their own self-conception or identity. In this chapter, I examine several conceptions of the nature of the dysfunctional beliefs most influential in the lives of people with OCD. This opens up a natural conceptual question of whether we should consider these beliefs in the strict *philosophical sense* or if these are merely belief-like attitudes. As I will enumerate, there are several problems with conceiving of these attitudes as ordinary beliefs. For the sake of clarity, in what follows I will refer to the phenomena at work in OCD as 'doxastic attitudes' as we evaluate different claims about the exact nature of these attitudes. Sam Kampa's definition of doxastic attitudes, for example, paints them as "belief-like propositionally structured thoughts."[159] We will work with this umbrella term/very broad definition that covers all the specific conceptions we will examine.

Theorists working in this area have focused their analyses on different 'puzzles' relating to OCD and beliefs. For example, Sam Kampa takes up the task of articulating why some manifestations of OCD exemplify weakness of will. Evan Taylor focuses instead on knowledge and whether/when folks with OCD can be said to have knowledge,

[159] Kampa, "Obsessive–Compulsive Akrasia," 5.

claiming no current theory is able to account for two senses of insight in OCD. Our present investigation has some areas of overlap with these 'puzzles' but departs from these framings to determine if any conception can fulfill several desiderata for a functioning theory of doxastic attitudes in OCD: First, we need an understanding of the nature of the doxastic attitudes we have been calling beliefs that fits with what we have said about these attitudes up until this point. For example, we know they can take several forms. Consider the different 'domains of dysfunctional beliefs' active in OCD, which range from an overestimation of threat all the way to perfectionism. Some manifestations concern mistakes the person fears they will make, while others concern realizing something about one's deeper self. Whatever the nature of these doxastic attitudes, they demonstrate a tremendous degree of flexibility.

Second, we need a clear conception of clinical insight that coheres with our understanding of the first-order doxastic attitudes in OCD. Adequate accounts must be able to explain not just instances of good insight but poor insight as well. We have examined cases of OCD where the agent considers her own behavior and thoughts to be irrational or unwarranted as well as cases where the agent is convinced of the truth of her obsessions. Our account of doxastic attitudes in OCD must be able to account for this dual manifestation of insight. Finally, we require an understanding of these attitudes that is flexible enough to at once avoid the issues plaguing what's called the Belief Thesis and other alternatives while at the same time accounting for the heterogeneity of OCD obsessions (where some have propositional content and others do not). That is, while

these attitudes appear to function like beliefs they may not possess all of the features constitutive of belief.

To begin, we will examine why we should suppose there is a puzzle about the attitudes in OCD in the first place. For, if OCD appears to involve dysfunctional beliefs, why isn't that the end of the story? This first section concerns the conceptual and philosophical problems with what some authors call the Belief Thesis, which posits that the doxastic attitudes at work in OCD are ordinary beliefs in the philosophical sense. Despite these problems, there are aspects of several approaches related to the Belief Thesis that are worth retaining because they partly help satisfy our desiderata for a satisfactory account. Sam Kampa's view that some manifestations of OCD exemplify epistemic akrasia raises the valuable insight that salience and attention-directedness are crucial for understanding the doxastic attitudes in OCD even if they are not ordinary beliefs, while the proposal I term 'doxastic wobble' underscores the role the experience of doubt plays in understanding these attitudes. From there, we shift to proposals from Noggle and others that these attitudes are 'quasi-beliefs', having some (but not all) of the properties of ordinary beliefs, a flexibility that helps account or the heterogeneity of experiences of OCD. Noting the shortcomings of these proposals, I settle on the view that the doxastic attitudes in OCD are (a form of) *construals* and that this conception preserves the advantages of existing views while cohering with our understanding of OCD from the previous chapters.

1. The 'Belief Thesis' and Its Discontents

Throughout our investigation into the moral psychology of OCD, we have relied upon the cognitive model of the disorder which depicts the primary issue in OCD as relating to dysfunctional domains of belief (such as threat overestimation, intolerance of uncertainty, responsibility for harm, and others). We have looked at the ways in which these 'beliefs' structure obsessions and drive compulsions, ultimately suggesting that many people with OCD fit the formal requirements for having guidance control (and thus also responsibility) for their behavior. Some authors also refer to the ways in which the attitudes in OCD are belief-like.[160] Following Evan Taylor, I will refer to this approach as the *Belief Thesis*.[161] Yet, there are significant hurdles for any account describing the doxastic attitudes in OCD as ordinary beliefs.

Synchronic Conflict. First, many people with OCD *appear* to hold conflicting beliefs about the world when they are in the grip of OCD. Noggle helpfully points out that when engaging in ERP treatment, people with OCD appear to hold conflicting beliefs *at the same time.*[162] The most straightforward problem with conceiving of these attitudes as ordinary beliefs concerns the rational requirements governing beliefs and the way they interact with other attitudes and capacities. For example, it is generally thought that a person cannot explicitly believe both P and ~P at the same time due to rational constraints on beliefs as a mental attitude. In moral psychology many theorists hold that

[160] Szalai, "Agency and Mental States in Obsessive-Compulsive Disorder," 54.
[161] Taylor, "Discordant Knowing," 6.
[162] Noggle, "Belief, Quasi-Belief, and Obsessive-Compulsive Disorder," 656.
Exposure Response Prevention (ERP) therapy involves identifying triggers of anxiety and obsession and then gradually exposing the patient to increasingly triggering (but controlled) circumstances so that they can slowly change their responses to stimuli in a 'safe' environment. ERP is generally considered one of the leading therapies for OCD.

when conflicting beliefs arise there is rational pressure to resolve the conflict such that the agent's beliefs are consistent with one another.[163]

Reflexive Metacognition / Insight. Second, people with fair or good insight into their disorder often themselves recognize that some of these 'beliefs' are not accurately tracking the world and are unlikely to be true. Nevertheless, they sometimes act in accordance with these 'beliefs'. A common example, and one with which Robert Noggle begins his seminal paper on this topic, is **Lightswitch**:

> I stand there and turn the light switch off and on, off and on, off and on, off and on. I can't make myself stop. It's crazy. What happens is that I have the thought that maybe I didn't completely turn it all the way off. Maybe the switch is somewhere inbetween the off and on position and a fire will start because of a short circuit. I know this does not make sense. Still, I have to keep on switching back and forth until I get it just right. I might stay there for ten or fifteen minutes. One time the light switch started smoking. Now my husband swears at me and yells, 'Leave the light switch alone or you really will start a fire![164]

In Lightswitch, the agent (whom Noggle calls Jane) articulates her thought process as she engages in a compulsive ritual driven by an obsession. Jane's obsessive thought is that a fire may start from an incomplete circuit resulting from switching the light only partially. To combat this, she switches the light back on and off again, only for the thought to reoccur and the cycle to begin again until it is 'just right'. But Jane also expresses the belief that her behavior is 'crazy' or irrational, saying "I know this does not make sense." Nevertheless, her switching the light appears to amount to acting upon a belief whose

[163] This roughly aligns with the sense of insight Taylor identifies as 'world-directed insight' which we examine later in the chapter.
[164] Osborn 41, c.f. Noggle 654. Noggle refers to the speaker as Jane (perhaps as Jane Doe, since Osborn does not disclose the name of the patient speaking).

veracity she seriously doubts. Not all manifestations of OCD involve this form of reflexive understanding (which Taylor refers to as self-reflective insight). When a person with OCD lacks significant insight into their disorder, it is much less likely that she will be able to recognize that her thought process is irrational. If we consider insight to concern beliefs, people with OCD appear to routinely act against seemingly genuinely held beliefs (such as Jane continuing to flip the lightswitch despite believing her behavior is "crazy").[165]

Problems with Knowing. An additional dimension of critique for the Belief Thesis, offered by Evan Taylor, is that it does not appear possible to explain a particular form of insight-as-knowledge: world-directed insight. Briefly, having world-directed insight amounts to recognition that the world is one way despite one's attitudes having contrary content. Suppose we are Jane from Lightswitch. If we accept the Belief Thesis then it would mean Jane believes both that the lightswitch poses no danger and that the lightswitch is a risk requiring action at the same time. But if this is true, there isn't a way for us to label Jane as 'knowing' that the lightswitch poses no danger even if she appears to have good insight. For Jane's good insight 'beliefs' to count as knowledge, she cannot be simultaneously holding an opposing belief. Taylor attributes this argument to what he terms "B-defeat" which entails that "knowledge requires the absence of doxastic conflict; knowledge cannot persist in the face of a doxastic competitor."[166] This critique stems

[165] Taylor, "Discordant Knowing," 4.
[166] Taylor, 7.

from Evan Taylor's desiderata that theories be capable of explaining two distinct senses of insight that can manifest in OCD.

Incomplete 'Beliefs': Third, there are certain properties beliefs have but which the doxastic attitudes at work in OCD seem to lack. Noggle identifies two such features: *affirmation* and *evidential response*. Noggle explains these features in the context of Lightswitch and so I will follow that approach. Noggle claims Jane has an ordinary belief that improperly flipped switches are not at risk of catching fire. He attributes this belief to her because she describes her own thought process as "crazy" and states that she knows it "does not make sense". This belief conflicts with Jane's related attitude, one with the content that 'improperly flipped switches are a fire hazard'. This doxastic attitude, however, lacks the properties of affirmation and evidence responsiveness. Regarding affirmation, Jane does not appear to agree with the attitude's content. In Noggle's terminology, Jane does not 'assent' to the content of her quasi-belief about the lightswitch fire hazard. We can see this in her own description of her articulated thought-process as not making sense - a sign that she herself is not convinced of its content even if she is entertaining it in her mind.[167]

Regarding evidence responsiveness, although Noggle does not make this connection, we might interpret Jane's ignoring of the *actual* smoking lightswitch (evidence that her ritual flipping of the switch is the real hazard) as demonstrating her quasi-belief's lack of sensitivity to reasons. We might imagine (outside of the details provided by Jane) that Jane's friend Tonya is a master electrician and has reassured her

[167] Noggle, 658.

that fires cannot start from improperly flipped lightswitches. Despite this reassurance and evidence, she continues her ritual behavior.

Despite these hurdles for the Belief Thesis, there are some lessons to be gained from recent attempts to solve the above puzzle while still depicting the relevant doxastic attitudes in OCD as ordinary beliefs. I would like to consider two such explanations of the attitudes in OCD. The first, provided by Sam Kampa, argues that at least some people with OCD are *epistemically akratic*. The second account is a fleshed-out version of an approach suggested (but not developed) by Evan Taylor claiming that OCD involves a kind of waffling between belief and nonbelief that I call *doxastic wobble*.

2. The Akratic Problem

One interesting approach for resolving the puzzle about doxastic attitudes in OCD comes from a recent piece by Sam Kampa, who raises the question of whether OCD is a form of epistemic akrasia. Epistemic Akrasia, also sometimes referred to as akrasia of interpretation or theoretical akrasia, occurs when an agent holds a belief *for which they believe they have insufficient evidence.* On first blush, the doxastic attitudes in OCD appear to be a good candidate for epistemic akrasia, since folks with OCD can hold conflicting belief-like attitudes about their situation. Consider, for example, the case of an agent with hit-and-run themed OCD who, while driving, is plagued by the idea that she has struck a pedestrian. If she continues driving on her route, we might be tempted to describe her situation as holding a belief for which she judges she has insufficient evidence. So, if her belief is “I have hit someone with my car” but she acts as though the

negation of this belief is true (does not stop by the side of the road, etc.) then she appears to act against a belief she holds.

Rorty thinks that many potential examples of this form only result in a sort of internal conflict or perhaps hypocrisy given the capacities for self-reflection that would be required.[168] This form of akrasia is intimately related to *theoretical/epistemic akrasia*, which entails holding a belief one believes is not properly backed by evidence. As Sophie Horowitz writes, "Just as an akratic agent acts in a way she believes she ought not act, an *epistemically* akratic agent believes something that she believes is unsupported by her evidence."[169] Epistemic akrasia would be voluntary and free behavior, implying that the epistemically akratic agent is responsible or blameworthy for her akrasia.

Consider again the example of Dr. S, who on the one hand appears to believe that he has hit a pedestrian, but also appears to believe that he has scant little evidence for believing he has hit a pedestrian. David Owens has claimed that it is not clear that epistemic akrasia is truly possible, given that such theoretical akrasia has several constraints that arguably cannot all be met: "Epistemic akrasia is possible only if (a) a person's (first-order) beliefs can diverge from his higher-order judgments about what it would be reasonable for him to believe and (b) these divergent (first-order) beliefs are freely and deliberately formed. Call (a) the *judgment condition* and (b) the *control condition*."[170] Most critiques of epistemic akrasia rely on the judgment condition being the one that cannot be met (since an agent cannot rationally believe p and its negation

[168] Rorty, "Akratic Break," 340.
[169] Horowitz, "Epistemic Akrasia," *Nous*, 48:4, 718.
[170] Owens, "Epistemic Akrasia," *The Monist*, 85:3, 381.

synchronically). Owens, for his part, thinks (b), the control condition, cannot be met in reality because it requires that agents have conscious control over belief formation at the appropriate levels. By contrast, Robert Osborne notes that philosophers have recently been more accepting of the idea that agents do not need voluntary doxastic control in order to have responsibility for their beliefs, although many still adhere to the voluntariness requirement.[171]

While I have argued that the ritualistic behavior in cases of OCD featuring good insight is voluntary and deliberate, I do not think the first-level doxastic attitudes generated by obsessions are voluntarily or deliberately formed. When Dr. S has the first-order doxastic attitude that she may have struck a pedestrian, this attitude is the product of her obsessions and fears, a sort of automatic response to them. Her second-order belief that this first-order belief is likely untrue seems to be voluntary inasmuch as any normal belief is. However, the control condition of theoretical akrasia requires that the *first-order belief* be voluntarily and deliberately formed. Again, some epistemologists, like Owens, have argued that it is not practically possible for the voluntariness requirement of epistemic akrasia to be met. Kampa is aware of this and works to craft an argument according to which agents can exercise downstream control over their attention-setting and thus fulfill the voluntariness requirement and demonstrate a concrete example of epistemic akrasia including in OCD.

In arguing that people with OCD are epistemically akratic, Kampa relies on the idea that agents with OCD can "control their doxastic attitudes by modulating their

[171] Osborne, "Doxastic Responsibility, Guidance Control, and Ownership of Belief," 82–83.

attention" and this is partly how he motivates his claim that some people with OCD can satisfy the control condition of epistemic akrasia. Kampa argues that interviews with agents with OCD reveal that changing what evidence they find salient, places it within the scope of their control and thus gives them what he calls epistemic guidance control.[172] Importantly, Kampa does not think that agents with untreated OCD have voluntary control of their obsessions - it is only after therapy that the agent gains this capacity.[173]

I would like to note, as I did toward the end of chapter 2 in the discussion of reason-responsiveness, that finding agents with OCD as being epistemically akratic generates the same concern as finding them responsible does - it strains our understanding of how freedom and compulsion interact with one another by suggesting that they are not mutually exclusive of one another. On the other hand, if Kampa's argument fails to demonstrate how people with OCD can have control over their obsessions then he has not shown that they are weak, since akrasia requires voluntary control of one's (relevant) behavior.

Kampa supports his control claim by referencing how focusing on different questions or ideas can lead an agent to focus on different pieces of evidence than before.[174] Kampa calls this 'level-splitting' wherein an agent is prompted to consider as relevant different features of her situation at different levels of specificity. The example Kampa uses to illustrate level-splitting occurs in an ordinary situation in which a person initially thinks they will win the lottery but, upon considering the whole of the evidence,

[172] Kampa, "Obsessive–Compulsive Akrasia," 8–13.
[173] Kampa, 10.
[174] Kampa, 10–11.

finds this initial belief to be unsupported by evidence. Kampa breaks these down into attitudes of distinct levels. The first-level belief might be "I will win the lottery" whereas the second-level belief would be "The balance of my reasons supports the belief that I will/will not win the lottery". Kampa wants to explain the difference between these two beliefs as relating to the fact that "Certain pieces of evidence are subjectively salient at different levels."[175] At the subjective level I might cite evidence about feeling lucky, or that there have been several winners from this retailer in the past, whereas at the objective level I would consider the actual odds of the lottery. Kampa thinks that considering these beliefs at different levels (his examples involve some sort of interpersonal questioning) prompts agents to pay attention to different elements of their environment, therefore explaining level-splitting.

I do not believe that Kampa succeeds in showing that the control requirement is met in the case of OCD. In cases of obsession, a person is primed by her cognitive biases to pay attention to particular evidence to the exclusion of other evidence. Kampa agrees with this much when he states that agents with OCD who have yet to receive treatment do not have voluntary control over their obsessions because they lack the ability to control their attention-directedness.[176] This means that, in the raw experience of an obsession there is not a native level of voluntary control over what evidence the agent is drawn to perceive as salient to her situation - rather, this must be developed over time in therapy. In cognitive therapy, patients learn to redirect their attention through considering

[175] Kampa, 9.
[176] Kampa, 10.

questions at different levels of specificity with their psychologist. It is only once they have begun this process that the person with OCD begins to cultivate the ability to redirect her attention away from what she is disposed to see as evidence.

One immediate reason to suppose such agents are not epistemically akratic is that we would be forced to adopt the position that these agents are not akratic when they lack treatment but *become* akratic once they begin treatment. This follows because akrasia is voluntary, and the agent only comes to have voluntary control over her attention-directedness after engaging in treatment. It does not make much sense to say that agents with OCD are not natively akratic but become so once they are exposed to considerations at different levels of specificity. Furthermore, on this understanding, it would only be accurate to say that treatment (and not OCD) is what makes a person with OCD able to satisfy the requirements of epistemic akrasia. Prior to that, they are not epistemically akratic (but can be brought to a place where they can be epistemically akratic). So, Kampa's view does not solve the puzzle about OCD we have set out to solve.

Another strike against Kampa's analysis is that it only pertains to a subset of OCD cases. Kampa is clear that not all cases of OCD qualify as epistemic akrasia.[177] Since Kampa's analysis is restricted to folks with OCD who experience doxastic obsessions, he has failed to provide an argument that OCD is itself an example of epistemic akrasia.

[177] Kampa, 2–5. Kampa provides a kind of indirect way in which his account can explain nondoxastic attitudes. This strategy relies on distinguishing between the nondoxastic obsession itself and appraisals which stem from that obsession and are themselves doxastic.

Instead, perhaps only some manifestations of OCD fit the akratic model.[178] If we seek a univocal theory or understanding of OCD 'without any gaps,' then Kampa's restriction provides us reason to reconsider whether OCD should be labeled epistemic akrasia. Kampa does not provide an explanation of *why* he focuses only on doxastic attitudes, since it seems his overarching goal is to find a concrete example of epistemic akrasia in the world as opposed to providing a seamless, unified explanation of the attitudes at work in OCD.

One strength of Kampa's analysis is his emphasis on the attention-related features of OCD as they relate to the doxastic attitudes in the disorder.[179] It is this insight that I wish to excise from Kampa's work. Consider the following passage from Cartwright, echoing the claim from Rachman and De Silva that the primary distress in OCD relates to the agent's own response to intrusive thoughts and obsessions:

> You see, there's something going on in their brains, some little neurotic fizz or glitch, which prevents them from dismissing the anomalous thoughts that most people shrug off without worry. The thoughts then get stuck like a broken record, and in their maddening repetitiveness, they start to feel like legitimate concerns, becoming a catastrophic challenge to the deepest facets of the person's identity. Every little thought about stabbing a loved one becomes concrete evidence of a real life homicidal tendency, and no matter how many compulsions they enact, the doubt would never be dispelled.[180]

In this passage, Cartwright describes the core of Salkovski's insights about the etiology and maintenance of OCD that distress is caused by the agent's focus on, and search for,

[178] Note, also, that this entails that a single agent who experiences both doxastic and non-doxastic obsessions is sometimes akratic but sometimes not, with the primary difference appearing to be the content of the obsession.
[179] Kampa, "Obsessive–Compulsive Akrasia," 6–10.
[180] Cartwright, 105. C.f. Rachman and De Silva, 6.

the meaning of intrusive thoughts and obsessions.[181] What I would like to emphasize about the above passage is the way in which Cartwright connects this feeling of importance with the idea of 'evidence'. Kampa's account of OCD rightly emphasizes the way in which people with the disorder appear to exhibit selective attention to certain considerations, where some are granted disproportionate salience to the agent's situation. In the final section of this chapter, I develop a proposal for understanding the doxastic attitudes in OCD that is able to incorporate the role of salience and attention without taking on the issues that plague Kampa's proposal.

3. 'Doxastic Wobble' (Belief Thesis Redux)

There is another approach to solving our puzzle, while holding on to the claim that OCD involves ordinary beliefs. On this proposal, the doxastic attitudes at work in OCD are beliefs, but the puzzle is resolved because the agent holds opposing ordinary beliefs only at *different* times. Taylor briefly considers this sort of approach and concludes that if it were true, it would be able to explain both senses of insight he has identified. Noggle also briefly considers this potential explanation before rejecting it due to evidence that patients with OCD engaging in Exposure Response Prevention therapy hold contradicting beliefs synchronically.[182] Let us briefly consider this approach, especially its relation to the experience of doubt in OCD.

Intolerance of uncertainty and insight are two epistemic dimensions of OCD we have discussed so far. A third epistemic element of this disorder concerns chronic doubt,

[181] Salkovskis, Forrester, and Richards, "Cognitive–Behavioural Approach to Understanding Obsessional Thinking," 57–58.
[182] Noggle, "Belief, Quasi-Belief, and Obsessive-Compulsive Disorder," 656.

as well as a feature that I will term 'doxastic wobble'. According to Nestadt et al, doubt is "the inability to make decisions because of a lack of certainty or confidence in the information available, both external, as in the sensory inputs, and internal, as in the integration of prior information."[183] While these researchers argue that doubt is the primary process at work in OCD and so the disorder is best understood as a dysfunction of decision-making, we need not adopt this doubt-centric model of OCD in order to incorporate the ways in which people with OCD struggle with doubt into our theorizing.

Doubt manifests in OCD in several ways. Several studies comparing folks with OCD to healthy controls have shown that people with OCD tend to express less confidence in their ability to make decisions than persons without OCD (even in cases where each group is demonstrably, equally accurate or knowledgeable). Additionally, enacting checking rituals appeared to actually *reduce* the agent's certainty. Furthermore, not only do persons with OCD take longer to make decisions in highly uncertain circumstances, they still have difficulty "acquiring information to make decisions" when deliberating in more certain circumstances.[184] Finally, regardless of the degree of insight a person demonstrates, she is nevertheless likely to experience what can be described as an 'oscillation of doubt' about her obsessions and obsessional beliefs.[185]

This oscillation of doubt or *doxastic wobble* complicates analysis of OCD, and specifically of insight, because it appears to mimic the effects of having poor insight in

[183] Nestadt et al., "Doubt and the Decision-Making Process in Obsessive-Compulsive Disorder," 4.
[184] Nestadt et al., 4.
[185] de Avila et al., "Level of Insight in Patients With Obsessive–Compulsive Disorder," 2; Nestadt et al., "Doubt and the Decision-Making Process in Obsessive-Compulsive Disorder."

that the agent appears to lack the knowledge that her obsessional beliefs are unsupported. For example, prior to the onset of an obsession, or well after it has dissipated, a person with OCD and fair to good insight into her condition would likely not endorse or put much stock into the idea that her house might burn down if she does not check on the stove before she leaves home.[186] She may have the context and understanding to see that she is prone to thoughts of this nature, and that checking the stove once or twice is sufficient to ensure the heating element is properly inert. During an exposure (real or therapeutic), the same agent may express conflicting ideas or thoughts about the state of the world (e.g., the stove is on and the stove is off).

Since we have used the example of Dr. S throughout other chapters, I will use his hit-and-run obsessions and compulsions as examples, although my claim is that doxastic wobble can impact just about any OCD belief. In his detailed account of the experience of OCD, Dr. S is driving on the highway on his way to an important exam when he is struck by the thought that he may have unwittingly struck a pedestrian or another car, injuring or killing them. Dr. S's thoughts oscillate quickly between describing his obsessional thought as "insane" on the one hand, and that it is possible he has been negligent and caused a catastrophe:

> Again, I try putting to rest this insane thought and that ugly feeling of guilt. 'Come on,' I think to myself, 'this is really insane!'
>
> But the awful feeling persists. The anxious pain says to me, 'You Really Did Hit Someone.' The attack is now in full control. Reality no longer has meaning. My sensory system is distorted. I have to get rid of the pain. Checking out this fantasy is the only way I know how.

[186] Nestadt et al., "Doubt and the Decision-Making Process in Obsessive-Compulsive Disorder"; de Avila et al., "Level of Insight in Patients With Obsessive–Compulsive Disorder."

> I start ruminating, 'Maybe I did hit someone and didn't realize it...Oh my God! I might have killed somebody! I have to go back and check.' Checking is the only way to calm the anxiety. It brings me closer to truth somehow. I can't live with the thought that I actually may have killed someone - I have to check it out.[187]

In this portion of his narrative, Dr. S describes the painful back and forth in his mind between seeing his thoughts as indicating an accident may have happened versus seeing his thoughts as part of a (distressing) "fantasy". This manifests as a tremendous feeling of doubt – doubt about what he may have done, doubt about his grip on reality, doubt about the sanity of his thought process, and so on. This doubt drives Dr. S's checking the side of the road over and over, and he expresses a need for truth or certainty about the matter.

Doxastic wobble is one way of representing the experience of doubt that is common to many instances of the disorder. Later on I will consider Evan Taylor's suggestion that also attempts to explain the doubt that pervades OCD, that OCD involves 'what if?' thoughts. This proposal may be grouped alongside others that depart from the belief thesis and instead focus on *quasi-beliefs.* In the final section, I try to incorporate the experience of doubt into my proposal that OCD involves construals.

4. Could OCD involve quasi-beliefs?

Thus far we have seen the deficits of the Belief Thesis and derivative views about the nature of the doxastic attitudes operating in OCD. Some of these deficits have led theorists like Noggle to propose that OCD involves belief-*like* attitudes (which share

[187] Rapoport, *The Boy Who Couldn't Stop Washing*, 23–27.

some but not all features of beliefs). Before we consider Noggle's proposal, a word about terminology. On a broad understanding of the term 'quasi-belief', many of the attitudes I will outline and consider below qualify as quasi-beliefs. This is because there is a thin sense in which any attitude that is belief-like is a quasi-belief (in the sense of having some, but not all, of the features constitutive of beliefs). In this general sense, an alief is a quasi-belief, and so too may be the attitude called 'construal' that I discuss at the end of this chapter. In this way, there is a sense in which any theory which posits belief-like attitudes can be labeled as involving quasi-beliefs. Problematically, Noggle uses the term 'quasi-belief' as a term of art to refer to the specific belief-like attitudes he thinks are at work in OCD. To avoid confusion between the general use of quasi-belief and the specific use of the term, I will refer to Noggle's proposal as **q-beliefs** and will use the more general 'quasi-beliefs' term to refer to of the general class incorporating several belief-like attitudes.

Noggle proposes that folks with OCD experience a mismatch between the content of their ordinary beliefs and the content of attitudes he calls *quasi-beliefs* and which we will call q-beliefs.[188] Q-beliefs are belief-like attitudes that share some properties of beliefs but not others. Importantly, a q-belief has propositional content that impacts an agent's "driving emotion and behavior in ways that would be rational if that content were true."[189] However, unlike beliefs, q-beliefs lack the properties of 'affirmation' and

[188] Noggle, "Belief, Quasi-Belief, and Obsessive-Compulsive Disorder," 658.
[189] Noggle, 658.

'evidential response'.[190] The quality of affirmation is a kind of *assent* on the part of the agent to an attitude that involves employing that attitude in practical and theoretical reasons, while evidential response refers to how sensitive the attitude is to either contrary or supporting evidence.[191] If an attitude lacks the property of affirmation, then it will not factor into the agent's practical and theoretical reasoning even when it would be relevant to do so. If an attitude lacks the property of evidential response, then it will not be sensitive to evidence that it is not true.[192]

Noggle argues that because q-beliefs lack both affirmation and evidential response, they can best explain the behavior we see in cases of OCD with good insight. Let's return to familiar example: checking the light switch. In this example, the agent speaking articulates her thought process as she engages in a compulsive ritual driven by an obsession. Her obsessive thought is that a fire may start from an incomplete circuit from switching the light only partially. To combat this, she switches the light back on and off again, only for the thought to reoccur and the cycle to begin again until it is 'just right'. So how do we understand Noggle's belief and q-belief thesis in the context of the lightswitch example? Noggle explains:

> 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

[190] Recall from earlier that a strike against the Belief Thesis is the fact that the doxastic attitudes in OCD appear to lack some of the formal properties of beliefs (such as affirmation and evidential response).
[191] Noggle, "Belief, Quasi-Belief, and Obsessive-Compulsive Disorder," 657.
[192] Noggle only writes that evidential response concerns sensitivity to confounding evidence - evidence that some belief the agents holds is false. I presume that evidential response must flow in both directions, such that if an attitude has evidential response is must be sensitive to evidence that it is true as well as false.

> 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. [193]

Here Noggle says the agent, Jane as he calls her, has an ordinary belief that improperly flipped switches are not at risk of catching fire. He attributes this belief to her because she describes her own thought process as "crazy" and states that she knows it "does not make sense". This belief conflicts with Jane's related attitude, one with the content that 'improperly flipped switches are a fire hazard'. This attitude, however, lacks the properties of affirmation and evidence responsiveness. Regarding affirmation, Jane does not appear to agree with the attitude's content. We can see this in her own description of her articulated thought-process as not making sense - a sign that she herself is not convinced of its content even if she is entertaining it in her mind. This quasi-belief does not play a role in Jane's overall practical rationality since we do not see her taking steps we would associate with taking the fire hazard seriously.

Before we consider the strengths and weaknesses of the q-beliefs proposal, it will be helpful to compare it to another proposal involving quasi-beliefs (in the general sense) suggested by Noggle, namely, that the quasi-beliefs in OCD are a different kind of doxastic attitude, one philosophers refer to as *aliefs*.

5. A Challenger Appears: Aliefs

[193] Noggle, 658.

Tamar Gendler is the first philosopher to posit the existence of aliefs and to outline their general properties. The application of aliefs to OCD cases appears to be first suggested by Ryan McKay and Daniel Dennett in passing without much elaboration or attribution to another author.[194] It is Noggle's 2016 work that provides the clearest articulation of how aliefs might be involved in OCD. We will construct this potential conception of OCD attitudes with reference to Gendler, Noggle, McKay, and Dennett.

According to Gendler in her seminal piece, "Beliefs and Aliefs":

> A paradigmatic *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. Aliefs may be either occurrent or dispositional.[195]

Aliefs are belief-like attitudes that have significant affective components. Note that aliefs lack propositional content - unlike beliefs, aliefs may be composed of representations. An immediate boon for the alief view of OCD is that obsessions can take many forms, not always the form of an attitude or mental state with propositional content. Sometimes the person experiences obsessions as an image, an idea, a thought, a possibility, and so on. Gendler does not cite OCD as a case involving aliefs, but she does reference phobias and other related experiences.[196]

Gendler uses a variety of colorful and compelling examples from recent studies on human experience to illustrate the nature of aliefs. These examples include activities

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[194] McKay and Dennett, "The Evolution of Misbelief," 499–500. McKay and Dennett do not attribute this view to Gendler or to Noggle. The latter's 2016 piece appears to be the first in-print proposal linking OCD and aliefs.
[195] Gendler, "Alief and Belief," 642–45.
[196] Here I use the term phobia loosely to refer to any number of manifestations of irrational and extensive fear associated with particular objects or contexts.

like walking across a glass-floored room high in the sky, touching one's mouth to a fake pile of vomit, eating chocolate fudge shaped like feces, drinking from a sterile (never used) bedpan, and so on. Gendler notes that, in these experiences, subjects do not report having a *belief* that the vomit is real or disgusting, a belief that the fudge has morphed into feces through alchemy. But they do report and exhibit a reticence to engage in these activities and discomfort when doing so:

> But alongside these beliefs there is something else going on. Although they *believe* that the items in question are harmless, they also *alieve* something very different. The alief has roughly the following content: "Filthy object! Contaminated! Stay away!"[197]

To be clear, we should not interpret 'content' here to refer to propositional content but instead some other form of content or value-laden-ness. This is not a problem because it is yet unclear whether the doxastic attitudes in OCD must have propositional content in order to fully explain the disorder. Note in this passage, Gendler describes the alief at work using language reminiscent of how people with OCD talk about their contamination obsessions.

Consider McKay and Dennett's brief mention of aliefs in the context of OCD:

> In a similar vein, patients with Obsessive Compulsive Disorder (OCD) generally don't believe that the repetitive behaviours they feel compelled to engage in are necessary to prevent some dreaded occurrence – but they may well alieve this. (The Diagnostic and Statistical Manual of Mental Disorders [...] contains a specifier for OCD with "poor insight," which denotes patients who fail to recognise that their obsessions and compulsions are "excessive or unreasonable." In such patients alief may be overlaid with belief.)[198]

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[197] Gendler, 636. To be fair to Gendler, I do not think she uses 'content' here to mean propositional content but instead some kind of other (perhaps representational or associative content). Emphasis original.
[198] McKay and Dennett, "The Evolution of Misbelief," 499–500.

Gendler herself does not apply aliefs to OCD and I have not found anyone (other than McKay and Dennett) who has suggested aliefs could be at work in OCD prior to Noggle's 2016 piece.

Noggle's primary reason for rejecting aliefs as being the doxastic attitudes involved in OCD is that aliefs lack propositional content (unlike his q-beliefs, which have propositional content). Noggle holds that what is crucial about his proposal is the mismatch of content between belief and quasi-belief and this can only come about if quasi-beliefs have propositional content. Another reason for requiring propositional content in the doxastic attitudes in OCD is that Noggle believes the experience of anxiety in OCD is more proposition-laden than raw affective experience. Citing the experience of Jane and the lightswitch he writes:

> 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.[199]

Here Noggle articulates the view that there is something essential about the doxastic attitudes (and conflict) in OCD that comes down to a clash between the propositional content of different attitudes. On the one hand is the reasoned, ordinary belief that the activity is safe and not risky, while on the other hand is the q-belief that the activity is unsafe and risky. Since this q-belief lacks certain properties that beliefs have, we avoid some of the problems that occur when we consider the possibility of holding two conflicting (full-fledged) beliefs at once. For example, there is no apparent irrationality in

[199] Noggle, "Belief, Quasi-Belief, and Obsessive-Compulsive Disorder," 660. Emphasis original.

holding a belief that X and a q-belief that ~X at the same time since consistency is not necessarily a feature of q-beliefs.

However, Noggle's embrace of a proposition-laden understanding of obsessions is, I believe, overstated. While many manifestations of obsessions take the form of explicit propositions, beliefs, or judgments, this is not universally true. Part of the complexity and heterogeneity of OCD is that obsessions can manifest as images and ideas that lack propositional content. Consider the person plagued by lewd or deranged images in his mind of the Virgin Mary. While many of these visions were cued by visual reminders of the Virgin Mary, no cue was strictly necessary – the man would experience these vivid images even if a Madonna was nowhere to be seen.[200] Or the man with OCD who had recurring, incredibly distressing intrusive images relating to assaulting children (which he did not want to do).[201] Or Raymond, a man with OCD who experienced vivid images of toxic filth spilling into and filling he streets of a theme park, endangering everyone present, including his family.[202]

A definite strength of the Alief Thesis is hinted at by Gendler's description of the sort of content in aliefs is that aliefs are felt with a certain immediacy and intensity that has affective features (as when she describes the possible content of an alief as "Filthy object!" and "Stay away!"). This is not unlike the vivid nature of many obsessions and the way in which they conjure strong feelings of anxiety. This vividness and affective component is a boon of the Alief Thesis that I hope my own proposal of construals is able

[200] Rachman and De Silva, *Obsessive-Compulsive Disorder*, 57.
[201] Rachman and De Silva, 96.
[202] Osborn, *Tormenting Thoughts and Secret Rituals*, 11–13.

to accommodate. Note that although Gendler expresses the content as propositions, they are not experienced that way by the agent. This leads to a second strength of the Alief Thesis.

One of our desiderata is to arrive at an explanation of the doxastic attitudes in OCD that is comprehensive – that is, it can account for a wide variety of manifestations of OCD (if not all of them), and so for both the doxastic attitudes that have propositional content and those that lack it. Another strength of the Alief Thesis over one involving q-beliefs is that it can explain obsessions that lack propositional content. Approaches which are unable to explain how it is that some obsessions lack propositional content while others do not are thus less flexible and have less explanatory power. Both the Alief Thesis and the Q-belief thesis have this drawback, but in opposite ways. This focus on propositional content is also the primary deficit of Evan Taylor's competing 'what if?' proposal, which I will briefly outline below.

6. Taylor on 'What if'?

According to Evan Taylor, there is a puzzle involved in understanding insight in OCD as it relates to *knowledge*. This puzzle arises when we distinguish between two senses of insight a person may have regarding her OCD. Current proposals for explaining the doxastic attitudes involved in OCD are unable to explain either one or the other of these two senses of insight. Taylor considers various ways to avoid the puzzle and rejects each before offering his novel view that "the obsessive thoughts at which insight is directed involve a particular kind of question-directed attitude," specifically a 'what if p?'

structure. Taylor suggests such what-if attitudes are at work in OCD, a possibility supported by relevant research into Generalized Anxiety Disorder.

Taylor divides the available approaches in terms of which sense of insight a given conception of OCD-related attitudes cannot explain. The first sense of insight is that which has 'world-directed' content. Taylor describes this sort of insight as having "first-order, world-directed content consisting of the negation of the content of the obsessive thought."[203] When Dr. S has the obsessive thought *the bump in the road just now means I have likely hit someone with my car,* having good insight would amount to knowing I definitely have not hit someone with my car.

The first grouping includes *beliefs*, *q-beliefs*, and *suspended judgments*. Each of these proposals is, in some way, unable to explain how the doxastic attitudes in OCD can "co-occur with knowledge of its negation" (as is thought to be the case when an agent displays world-directed insight). In a word, how is it that one can hold a belief with content P while *also* holding a belief/q-belief/suspended judgment with content that is the negation of the belief (~P)? We have already discussed how this works with the Belief Thesis, but we must say at least briefly how q-beliefs and suspended judgments encounter similar problems. Taylor indicates that even though q-beliefs lack assent and evidential responsiveness, they still have "*some* sort of commitment to the truth of the content."[204] Similarly, suspended judgments are unable to account for world-directed insight because if the agent genuinely holds a belief that P, then any sort of suspended judgment that ~P

[203] Taylor, "Discordant Knowing," 4.
[204] Taylor, 8.

will spoil the claim that the agent 'knows' P (in the form of having world-directed insight).

The second grouping includes *aliefs* and *imagination*. These proposals are in some way unable to explain how the doxastic attitudes at work in OCD are "rationally evaluable."[205] This means these proposals cannot account for self-reflective insight, which is the second sense of insight Taylor identifies. Taylor describes this form of insight as the recognition that having a particular obsessive thought is irrational, or "the recognition is that there is something epistemically flawed about one of the subject's first-order thoughts."[206] So when Dr. S has the obsessive thought that the bump in the road just now means I have hit someone with my car, having good insight would amount to thinking it is irrational to think the bump in the road means I have hit someone. The reason aliefs and imagination are unable to account for self-directed insight is that they are not committed to the truth in the same way as the previous set of doxastic attitudes is thought to be. Taylor argues that if it is not possible for an alief (or an imagining) to be irrational then it is not possible for one to think that having or experiencing the alief/imagining is irrational.[207] Taylor's arguments serve to highlight the complex nature of insight in OCD, as well as the difficulty we can have in arriving at an accurate and working understanding of the phenomenon.[208]

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[205] Taylor, 6.
[206] Taylor, 4–5.
[207] Taylor, 10–11.
[208] One note before evaluating Taylor's argument: there is a sense in which self-reflective insight is derivative of world-directed insight. When I believe having a certain thought is irrational, it is often because it would be irrational to think something false about the world. When I think it is irrational to interpret every pothole in the road as a pedestrian victim, it is because that belief or

Taylor's own proposal is that the attitudes at work in OCD are 'what if?' questions. He describes these as "question-directed attitude[s]" that do not have "declarative content" (in the sense that believing "that P" has) but rather content of "what if P?" He does not develop this proposal extensively, indicating that these attitudes are typically associated with Generalized Anxiety Disorder and little research has been done regarding OCD and what-if attitudes. Taylor finds that the beginnings of this proposal do not appear to run into the same issues the other two groupings do, and that what-if attitudes can plausibly account for both world-directed and self-reflective insight.

One concern, which also plagues other approaches to explaining doxastic attitudes in OCD, is that not all obsessions contain propositional content. Some obsessions are images, ideas, or seemings that do not easily transform into what-if questions. And if they *can* so transform, it is unclear whether people with non-doxastic obsessions experience them as questions. Some reports of the experience of OCD often involve 'what if?' sorts of thoughts even if others don't.

Taylor's proposal would seem to omit, for example, folks with OCD who experience obsessions as involving distressing and upsetting images and ideas in their mind. Consider Rose Cartwright's descriptions of what it is like to have sexuality-themed obsessions that involves what-if elements but also others. Cartwright describes intrusive images of nudity, ideas about those around her nude, and obsessives over whether her attention to a woman's body says anything about her sexuality:

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idea is not representing the world correctly. And so it seems to me that the irrationality of holding certain beliefs derives from their content being materially false about the state of the world.

> Halfway down I stopped like a yanked dog to see 'BEACH BODIES!' on a gossip mag. A woman with massive tits sun-bathing on the beach. A lump shot to my throat and the doubts came in a split-second flurry: *Why did I notice her? What if I'm not really ill? What if these thoughts are the truth? What if I am lying to myself?* [...] *Maybe the fact I noticed her means I'm gay? No. I have OCD. I know who I am. But if I did have OCD surely I wouldn't question it? So, maybe I'm gay?*[209]

The triggering event for Cartwright is that her attention is drawn to a magazine depicting a woman's body. Her attention is particularly drawn to the woman's breasts which provokes a feeling of anxiety. She then turns her attention upon this thought to determine if it is meaningful, or indicative of anything about her sexuality or identity, and wrestles with doubt while trying to ignore these ideas. A combination of doxastic attitudes with propositional content and attitudes without it is at work in the author's experience. On the one hand we have the image of the woman's body, and on the other we have 'what if' questions that have definite content. Both form a portion of the experience of cognition in OCD, and so each must play a role in the explanation of the doxastic attitudes in OCD.

Even if we do not endorse Taylor's what-if proposal, there is a boon from this view I would like to preserve in my own proposal that follows: motivation. Taylor brings up in passing that a benefit of his proposal is that it can better explain why people with OCD are motivated to engage in compulsive behavior because of their obsessions.[210] Recall Dr. S and the various ways in which his narrative invokes the question of 'what if?' The uncertainty and doubt endemic to his experience motivate him to engage in

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[209] Cartwright, *Pure*, 103-4 emphasis original. See also Cartwright's description of an upsetting celebration of Oktoberfest where actual nudity often cued obsessive sexual thoughts and images (38-42) and a similar episode in which she is unable to concentrate on social interactions because her attention is continually on the speakers' genitals (28). Emphasis original.
[210] Taylor, "Discordant Knowing," 18–19.

compulsive checking. This idea that obsessions (or the doxastic attitudes involved in them) somehow motivate people with OCD to act compulsively is one I would like to assimilate into my own positive proposal.

Now that we have reviewed several attempts to solve the puzzle about OCD and their various upsides and drawbacks, we are finally able to consider this new proposal, that OCD involves what are called *construals*.

7. Novel Proposal: Construals

Up to this point, we have laid out a variety of desiderata for a workable theory of the nature of the doxastic attitudes at work in OCD and considered the degree to which different proposals are able to meet these desiderata. Along the way, I have noted strengths of each proposal that might contribute to a more complete conception of these doxastic attitudes and the dynamic at work in OCD. A litany of problems arises when we consider these attitudes to be ordinary beliefs, and only some of them are resolved with a shift toward seeing OCD as involving a combination of ordinary beliefs and some form of quasi-belief (such as q-beliefs or aliefs). How can we arrive at a conception of these attitudes that is at once flexible regarding the content or nature of the doxastic attitude but also can account for the ways in which some people with OCD have insight into the nature of these attitudes?

I suggest there is another option for understanding doxastic attitudes in OCD, one which retains many of the strengths of the foregoing proposals while avoiding their pitfalls. This proposal relies on the analysis of emotion by philosopher Robert C. Roberts, requiring understanding a new kind of attitude, that of **construal**. Roberts is concerned

with advancing our understanding of emotions and their relation to human agency. He proposes that emotions are "concern-based construals" as a fundamental paradigm for capturing the experiences we typically associate with having an emotion.[211] Despite this context of Roberts' discussion, his notion of a construal is applicable to understanding the doxastic attitudes in OCD.

Roberts provides several heuristics for understanding his account of emotions as concern-based construals. One example of a construal arises in the experience of hearing someone well-dressed and similarly mannered speak ungrammatically. When we hear this mistake, our perception of the speaker shifts in a way that allows us to become aware of our *previous* impression of the speaker, an impression we had previously been unaware of (Roberts, 69-70). We move from construing the young woman as proper, 'well-bred', educated and instead construe her as a pretender to a higher class or a background which we no longer see. Presumably the difference in construals (pre-error and post-error) in this example is based on existing background expectations about linguistic felicity or what comprises an educated upbringing. If someone lacking this background or upbringing listens to the woman speak, they may not perceive any shift at all in how they construe her.[212]

[211] Roberts, "Emotions: An Essay in Aid of Moral Psychology," 64. Roberts does not task himself with providing a theory of emotions proper, but instead suggests an account of emotion that is able to fulfill our basic desiderata for any working theory of emotions.
[212] Roberts, 69–70.

Figure 1: My Wife and My Mother-in-Law, William Ely Hill (1915).

Another, more evocative example is that of the classic drawing which can sometimes be seen as a young woman looking away and at other times as an old woman looking down.[213] Roberts points out that often when seeing this drawing, viewers will actively attempt to 'see' the other figure to no avail. Roberts supposes this is because there is not just belief or judgment going on here but a *perception* as well - viewers cannot will themselves to perceive that which they do not. He articulates this perception as being of "an organization of these sense-perceptible lines that makes for the picture's being that of an old woman or a young one."[214] Since each of these perceptions (of young woman versus old woman) can be an experience when viewing the exact same picture, Roberts concludes that these construals are **subjective**. Importantly, neither the old woman or young woman is the 'proper' construal of the image: "Different as the construals are, neither is to be preferred to the other, absent some special conventional circumstances."[215] From such examples Roberts derives a running list of features of

[213] Hill, William Ely. *Wikimedia Commons*. Originally appeared in *Puck*, volume 78, number 2018 (1915) page 11. Accessed https://commons.wikimedia.org/wiki/File:My_Wife_and_My_Mother-in-Law.jpg (06/01/2022). C.f. Roberts, 71.
[214] Roberts, 71.
[215] Roberts, 71.

construals simpliciter (that is, not relating to any particular feeling or emotion). Each of these aspects of construal is paraphrased from Roberts.

Construals...

1. ...have **immediacy** akin to sense experiences,
    a. Construals are not belief, judgment, etc,
2. ...are not *mere* sense-impressions,
3. ...occur with an 'in terms of' relation (are "synthetic" and "constructive"), meaning that it is not a mere perception of properties but rather "an organization of the sense-perceptible lines that makes for the picture's being that of an old woman or a young one."[216]
4. ...are subjective (subject-dependent) although occasionally subject to truth conditions,
5. ...focus on a small number of elements "with the rest of the construct in the 'background'"
6. ...typically exclude opposing construals,
7. ...do not need to be 'states of consciousness'
8. ...have "an 'emotional' character" to them,
9. ...come in degrees,
10. ...can involve several different mental states and attitudes,
11. ...are sometimes under the voluntary control of the agent.[217]

As mental attitudes and phenomena, construals are flexible and heterogenous in that they can take any number of forms. At its base, construal is **'seeing-as'** – the disposition to interpret the object of construal in a certain light rather than another. I will consider how we can make use of 'construals' in understanding the doxastic attitudes involved in OCD. I will leave aside the question of whether the attitudes involved in OCD further align with Roberts' view of *emotions* as concern-based construals.[218]

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[216] Roberts, 71.
[217] Paraphrased and quoted from Roberts, 71.
[218] I will note that Roberts thinks "concerns, cares, desires, loves, interests, attachments, and enthusiasms are dispositions to emotion." (79) We might, then, think that obsession is a disposition to emotion which explains its structural similarity to caring.

What I propose is that the first-order experiences of folks with OCD can be understood as construals of harm, danger, risk, or 'not right'. In instances of good insight, the agent recognizes that her construal is at odds with the truth of the matter. That is, she forms ordinary second-order beliefs about her responsibility, about what to do, etc. knowing that they conflict with her construal of the situation. People with poor insight are either unaware that their construals are inaccurate/unwarranted or they are unable to maintain or act from beliefs contrary to the construal.

Why should we suppose that a construal-based understanding of attitudes in OCD is preferrable to any of the previous attempts discussed (ordinary beliefs, q-beliefs, aliefs, 'what if's)? Understanding obsessions in OCD as construals captures several different features of the experience of OCD that other conceptions may have difficulty with, while preserving the features that make these conceptions attractive in the first place. It also provides an account of how we can understand the behavior of a person who claims to know X is not true but acts as though X is true.

Lacking Assent. Earlier we saw that one draw of quasi-belief approaches (both q-beliefs and aliefs) is that they can account for the way in which some of the doxastic attitudes in OCD lack 'assent'. Recall that Noggle posits q-beliefs as being only belief-like partly because the agent need not assent to the content of a q-belief. Construals (including emotional ones) operate similarly: an agent need not assent to the content of their construal even if they experience it (whereas if the attitude were a proper belief assent would be required).[219]

[219] Roberts, "Emotions: An Essay in Aid of Moral Psychology," 89.

Metaphysical paucity. We interpret the obsessions agents have as construals of danger, in light of which they then form beliefs. For example, Windsor Flynn construes bathing her child when alone as dangerous. She then forms a belief about this construal, whether it is that the construal is false, accurate, or somewhere in-between. This can explain the confusion and doubt folks with OCD experience in their practical deliberations. There is, on the one hand, the vivid sense that something is risky, dangerous, infected, poisoned, contaminated, and so on. This mimics the kind of intensity and immediacy that we saw as a strength of the Alief Thesis. On the other hand is an ordinary belief that is formed based on evidence, etc. that may challenge this construal. Suppose she forms the belief that there is nothing inordinately dangerous about bathing children at home. She may, nevertheless, act against this belief and in line with the construal that it is dangerous (e.g., only bathe her child when someone else is present).

Explains Insight. Second, this approach is easily able to accommodate the two senses of insight – world-directed and self-reflective – that Taylor thinks any account of doxastic attitudes in OCD must cover. Recall, Taylor thinks the task before us requires that we be able to explain both the world-directed and self-reflective senses of insight. We can recognize several 'construal patterns' at work in OCD which are then triggered in different situations, often based on what that person cares about. In previous chapters, I have introduced the notion of 'dysfunctional belief domains' in psychology regarding OCD. These include intolerance of uncertainty, moral thought-act fusion, perfectionism, and others. Understanding of these domains as patterns of construal allows us to say, for example, that many different thematic manifestations of obsessions and compulsions

share a pattern of construal without labeling them as beliefs (and all that comes with that). Construals need not be consciously perceived by agents (but can be). This allows us to frame insight in terms of conscious awareness of the mismatch between construal of a situation and belief about the situation.

We might ask if the construal view satisfies Taylor's requirements of being able to explain both world-directed insight as well as self-reflective insight. Part of the dynamic at work in Taylor's critique is that all of the considered accounts are inflexible in ways that let them account for one sense of insight but not the other. Since construals are so heterogenous and flexible as attitudes, this proposal can account for both senses of insight Taylor is concerned with. Consider the person with OCD who construes shaking hands as risky or dangerous due to contamination despite knowing that shaking hands is not an especially effective form of germ transmission. This person can still be said to know that shaking hands is not risky despite construing it as risky in the same way that, when viewing the image above, I can know that the image contains both the young and old women while only construing it in one of these ways. This confirms the construal view can depict world-directed insight. Alternately, someone with OCD can think that it is irrational for them to think that shaking hands is risky despite construing it as such because construals can (but need not) contain rationally evaluable content. This demonstrates that the loose and lax conditions of construal are an advantage when considering a disorder as heterogenous as OCD.

Attention and Salience. Another strength of the Construal thesis is that it can explain the way in which cognition in OCD goes beyond merely focusing on different

features of a situation than ordinary agents would. Instead, there is a kind of organizing or sense-making that takes place within a construal that is not explained fully by merely relying on attention biases at work in OCD. Consider what Roberts says about an example in which two friends, Lem and Mel, who each react to the very same stormy evening ahead of them, with one person focusing on the features that make it dangerous while the other picks out features that justify blaming the other friend:

> It is correct to say that Lem's anger and fear are about the same situation [as Mel's are] but with different features of that situation salient; but that analysis of the difference does not capture the way in which the various features of the situation are grouped and related to one another in the different emotions.[220]

Again, Roberts' focus is on emotional construals, but, more generally, holding different construals, even non-emotional ones, amounts to more than merely focusing on different pieces of evidence - it also orders and groups together the evidence in a particular way, painting a kind of story for the agent about what is at stake and what is most important in the given situation. When a person with OCD construes a situation as harmful or dangerous, this construal goes beyond merely identifying different salient pieces of information in the environment and coming to a different conclusion than other agents. Instead, it involves a kind of structuring principle for the agent that not only draws out attention to particular features in the environment but also relates them to one another in a particular way.

My proposal of construals is, I believe, superior on this score to the analysis provided by Kampa regarding doxastic attitudes in OCD. While we both reference to

[220] Roberts, 79.

attention and salience, Kampa's view generates the potential problem that people with OCD are epistemically akratic in virtue of having voluntary control of their obsessions (even if this claim is highly qualified). In comparison, my proposal involving construals avoids the weakness problem by explaining changes in attention-direction in a way that reveals they are not necessarily under the voluntary control of the agent. It does not undermine my proposal if we acknowledge that therapy and other cognitive training can allow someone to have downstream causal influence on their attention, since construals can be affected by external influences even if they are not strictly under the voluntary control of the agent. This also goes hand in hand with understanding obsessions along the dimension of cognitive biases, since construals can operate in ways similar to cognitive biases. In most cases an agent requires some level of input from the outside world to determine for herself that her cognition is biased in one way or another and construals are compatible with this picture.

Motivation & Connection to Caring. In laying out his theory of emotion, Roberts ties emotional construals closely to that which an agent cares about: "To be afraid of heights is not just to see them as a danger to something or other; it requires that something the subject holds dear appear to him threatened."[221] The content of an obsession, like that of certain emotions as Roberts defines them, is reflective of the person's concerns and cares. This is why obsessions can be so terribly distressing - they present the possibility that the agent is the very thing she think most harmful, most damaging, most dangerous. Recall Dr. S recounting the horror of the implications of his

[221] Roberts, 79.

hitting a pedestrian (when he has done no such thing). He cannot bear to conceive of himself as someone so careless as to hurt or kill someone. But the construal of the situation as dangerous or warranting alarm drives him to continually search the side of the road for some certainty about the clash between his construal and his belief. In Chapter 3 I gave the example of Maggie, who is so fearful for her own health and that of her loved ones that she takes extreme measures to cleanse herself and avoid certain places and activities. Her care effectively motivates her to engage in compulsive behaviors as a means of warding off the risk she perceives to herself and those around her. This motivational feature is reminiscent of the way what-if attitudes can motivate an agent to engage in compulsive behavior. Construals are able to explain why it is that obsessions motivate an agent to act compulsively, and they do so precisely by connecting with the way our cares motivate us to act.

Univocal theory of obsessions. Throughout this chapter I have made the argument that various approaches to explaining the doxastic attitudes at work in OCD are deficient insofar as they are unable to account for a subset of cases of OCD.[222] Specifically, I have noted that not all obsessions present themselves as attitudes with propositional content; some are images, ideas, 'feelings' and so on. This is a lacuna of several of the accounts discussed earlier in this chapter. Construals simpliciter do not have a single form – they can manifest as having propositional content but can also manifest in ways that lack propositional content. This provides my account the flexibility that other accounts lack. Earlier, while discussing the Alief Thesis, I described several

[222] Taylor briefly mentions a concern along these dimensions. Taylor, "Discordant Knowing," 16.

radically different manifestations of OCD whose obsessional components all lack propositional content. For example, Raymond (who experiences vivid images of toxic waste flooding public areas) construes the area around him as in danger although he does not necessarily form a thought with propositional content corresponding to these images (although this is possible and within the bounds of the features of construals simpliciter). Construals can associate with a wide variety of other mental attitudes, and this places them in a unique position with regard to our puzzle about the attitudes involved in OCD.

8. Conclusion

Throughout this chapter, we have endeavored to understand not just the puzzling features surrounding the attitudes at work in OCD but to also evaluate various proposals for explaining or resolving these puzzles. There are straightforward issues with conceiving of the doxastic attitudes at work in OCD as beliefs, but as we have seen each of these proposals has both strengths and deficits of their own. I have suggested that a novel proposal, based on Robert Roberts' theory of emotional construals, is able to provide all the strengths with none of the deficits of these various views. The flexibility of construals and their heterogeneity are precisely what is needed to explain the complexities of OCD as a disorder.

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Looking Back & Looking Forward: Concluding Remarks

In the first chapter, we examined the way misrepresentations of OCD in moral philosophy have painted the disorder as one more example of philosophical compulsive action. Part of this dynamic is the association between philosophical compulsion (which inhibits freedom and responsibility) and OCD as one example of these sorts of compulsions. I traced the way in which OCD has been treated by moral philosophers as an example of philosophical compulsion in that it is likened to other compulsion cases in philosophy. This led to a discussion of some of the ways specific features of the disorder complicate our understanding of how OCD fits into our broader understanding of human agency. This discussion also set the stage for our detailed foray into understanding more about OCD as a disorder and the myriad ways in which a moral psychology of OCD is both necessary and philosophically illuminating for studying human agency.

In the introduction of this investigation into the moral psychology of obsessive-compulsive disorder, I suggested that there is a kind of hierarchy of agency that many theorists explicitly or implicitly reference. This hierarchy depicts compelled agents as lacking the freedom required to be morally responsible for their behavior, employing these agents as a sort of foil for free and responsible agency. This is particularly true of reason-responsive theories of control and responsibility. In Chapter 2, we looked at the ways in which most folks with OCD are able to meet the formal requirements for being labeled as sufficiently reason-responsive to have guidance control over their behavior and thus be considered free and responsible for actions taken in the context of OCD. This revealed that agents with OCD are not insufficiently reactive to reasons – instead, they

are especially receptive to reasons, treating many considerations as reasons for action which other agents may not recognize. But this puts pressure on our acceptance of an agential hierarchy that places compulsion and freedom opposite one another. If most folks with OCD are sufficiently reason-responsive, what are we to make of the traditional assumption that freedom and compulsion oppose one another? After all, if these agents are morally responsible then it would be appropriate in some circumstances to *hold* them responsible despite an intuition that agents are not blameworthy for actions taken in the context of their disorder. Throughout that chapter, I tied this sensitivity to reasons explicitly to the powerful dysfunctional 'beliefs' and biases at work in OCD. The vast majority of folks with OCD struggle with these dysfunctional cognitive patterns despite possessing an awareness that their behavior is disordered, senseless, and so on. Clinically, these agents are said to have fair to good insight into their disorder. But understanding OCD requires recognizing that a minority of folks with OCD lack significant insight into their disorder as well, which served as the focus for chapter 3.

When we examine poor insight cases of OCD, surprisingly we see that obsession in this context has the same structure as the human capacity of caring. Often these folks, who are the most ill, order many parts of their lives around appeasing their obsessive thoughts with compulsive rituals. Their obsessions begin to take on an outsized role in their deliberation and reasoning, taking up increasing space in their deliberative horizon and ultimately shouldering out the agent's other cares and values. This would potentially upset our understanding of an agential hierarchy which has traditionally considered obsessions as external to the agent and not attitudes which 'speak for her' in any robust

sense the way internal attitudes do. But if some cases of OCD resemble caring, and if all cares are internal, then we begin to have a difficult time unraveling the degree to which we should interpret poor insight obsessions as speaking for the agent in any meaningful sense.

I suggested in chapter 3 that the idea of 'disordered caring' can help us scaffold an understanding of over-valued ideas in psychology and their connection to what the agent cares about or values. Disordered caring consists in a variety of primarily epistemic and evaluative deficits which combine to help explain why people with poor insight into their OCD place the objects of their obsessions as central in their life. That OCD involves some form of epistemic deficit (or suite of such deficits) has loomed throughout our investigation until chapter 4 when we were positioned to evaluate the exact nature of the sorts of doxastic attitudes at work in OCD. Here, again, we see the ways in which the peculiarities of OCD as a disorder disrupt the traditional hierarchy of agency prominent in action theory but this time with respect to belief. It was here, too, that we recognized the need to have a univocal explanation of what is going on in OCD. Whatever our conclusion, it should apply not just to fair and good insight cases, but also those cases of poor or absent insight which help comprise the spectrum of experiences in OCD.

The puzzle in chapter 4 was how we could balance the idea that OCD involves some kind of doxastic attitude with the problems that arise from treating these attitudes as proper beliefs in the philosophical sense. This explanation should ideally also comport with (if not help explain) the oddities we noticed throughout chapter 2 relating to reason-responsiveness and its connection to these 'beliefs'. We considered a variety of proposals

from different philosophers about the nature of these attitudes before recognizing the need for a more flexible account. This led to my proposal that the doxastic attitudes in OCD are akin to emotional construals.

I argued that construals can deliver the strengths of previous explanations of these doxastic attitudes but without taking on their deficits as well. Not only does the construal view of OCD give us the flexibility to account for both good and poor insight cases, it also helps explain the way these construals relate to reason-recognition. One of the strengths of Sam Kampa's analysis of OCD is the fact that OCD involves differences in attention-direction and salience from typical agents, such that certain features of the person's situation become especially relevant in their assessment over other features which might seem less relevant or outlandish. In chapter 2 we described this as an over-receptivity to reasons, but with our new construal conception of OCD we can properly understand this dimension of OCD as relating to what features of her environment or deliberative considerations her attention is most drawn to. Recall Windsor Flynn, plagued with postpartum OCD and obsessions that she might bring harm to her own child, who interprets all manner of thoughts, considerations, features of her environment, as especially relevant for her child's safety (and for whether Flynn will 'freak out' the way she fears).

While the construal conception of OCD has resolved some of our concerns about the way OCD fits into a hierarchy of agency, it also points the way toward the next steps in the project of having a complete moral psychology of OCD. For one, if people with OCD are morally responsible then we require a different explanation for why we should

not blame these agents, an explanation which cannot rest upon the behavior being 'compelled' but instead too difficult to expect someone to overcome. Is it appropriate to blame an agent for failing to recognize that her construal of the situation as dangerous or harmful is incorrect? Where is the threshold for blameworthiness that is based on this notion of difficulty? How responsible for our construals are we as agents, and what connection does this have to control over attention-directedness and salience? Given the power of these doxastic attitudes in the mechanics of the disorder, these questions point to the need to address doxastic responsibility – or responsibility for one's beliefs and epistemic states – and how this relate

s to OCD in good as well as poor insight cases. There remains much to do, but I am hopeful that my contribution has advanced the discussion within moral psychology and specifically with regard to philosophical conceptions of OCD.