

NORMAL AND OBSESSIONAL DOUBT : KNOWING THE DIFFERENCE

Historically doubt has always featured as a major part of OCD. Earlier in the last century OCD was even called "the illness of doubt".

Although obsessional intrusions may take various forms, often it is the thought that "the door may not be locked", that "possibly my hands are still dirty", that "perhaps I said the wrong thing last night", "that I could throw out a valuable by mistake" which causes anxiety.

It is rare for a person with OCD to believe with 100% certainty that the imagined aversive event is completely true or absolutely bound to happen. Usually the intrusive thought is characterised by differing degrees of doubt. Doubting may lead onto further mental activities, in particular rumination: continual questioning (whether an action is right), or thrashing through an analysis (of a problem to be sure the answer is right or all the answers are covered); replaying daily routines in the head in case a sequence was missed; monitoring or analysing behavior to look for any sign of a certain behavior. The doubt may well of course lead on to the more well-known compulsive activities such as repetitive checking "just in case".

In most cognitive models of thinking about intrusions, doubting obsessions arise as a consequence of traits of: perfectionism, intolerance of uncertainty, or over-responsibility, or perhaps due to a more pervasive personal characteristic such as a lack of self-confidence, and it is these traits which causes the person to react nervously and disproportionately to any suspicion of doubt. Nevertheless when the doubt arrives it feels

real, very gripping and lived-in, and for some people it is the doubt itself and not necessarily its consequences which cause distress.

The nasty part of doubting is that even if the person feels the doubt is 99% improbable, the thought that it might "just" be true can be enough to generate discomfort. In many cases, of course, it is what will be the result (that is to say the secondary consequences, if the doubt is founded) which leads to anxious feelings.

Our research* has shown, however, that it is important to distinguish between initial thoughts of doubt and the subsequent thoughts about the consequences, since these two thought stages are to some degree independent. An initial doubt could take the form of "maybe my hands are contaminated", and the subsequent thoughts of the consequences would then be "and if they are contaminated, I will contaminate my family and my belongings". This subsequent thought may then spiral off into further consequences such as "and then my house will become contaminated" or "I will make everyone ill".

For most people, a high investment in the probability of the initial doubt is also accompanied by a strong feeling in the reality of the consequences, even to the extent that the belief in the consequences is the major factor associated with anxiety. But for a substantial proportion of people with OCD, the belief in the initial doubt rather than a preoccupation with consequences seems linked both to anxiety and to the need to perform the ritual or neutralisation.

For example a lady is constantly questioning whether she at times appears more like a man or a woman in her gestures, and will consequently spend hours analysing her behaviors. But she can't precisely pinpoint any feared consequence even if she does appear either too much one or the other. The preoccupying idea is maybe she could.

Another person doubts whether he has thrown out empty cartons and wrappers unawares in the rubbish. But he admits there are few consequences even if he were to discover he has inadvertently thrown out such an item. Here again the doubt itself is the obsession.

In these cases we feel it is important to distinguish between normal and obsessional doubt, since people frequently go into obsessional doubt, believing it is a normal type of question to ask themselves. Indeed, frequently the content of the doubt may be normal. But unfortunately whereas normal questioning usually produces a search for information to resolve the doubt, obsessional questioning leads away from real sense information into repeating and rehearsing the doubt (see Table 1). If information is sought out then the OCD doubt quickly takes over and dismisses it as not relevant. Often there is no real reason for doubting and usually the person has all the information they need from the senses to be as sure as they need to be, but the OCD comes along with an hypothetical story which makes the person doubt their initial judgement.

For example, the man who continually doubted he had thrown out an (anyway unwanted) item was led to doubt by a narrative leading him to believe he was possibly the sort of person who could inadvertently miss out on an event. The lady who monitored herself felt she might not be on the ball if she couldn't recall the meaning of her every gesture.

The clinical implications are that in such doubting obsessions, the obsession begins at the point the doubt arrives, even if it appears normal. The reasons for doubting are not based in reality but are rather subjectively generated. But if the person goes into the doubt believing it to be a worthwhile question, s/he is likely to be sucked into a spiral

of doubt, not resolution. Hence the doubt is best challenged as obsessional doubt from the outset.

Table 1. Distinguishing authentic from obsessional doubt.

<i>Authentic Doubt</i>	<i>Obsessional Doubt</i>
1. The doubt or questioning is justified by an event or signal from reality.	1. The doubt or questioning is triggered purely by an internal state.
2. A specific question is posed which can be answered by an identifiable piece of knowledge.	2. The doubt takes the form of a vague "maybe" and does not indicate any precise information.
3. Real resources or senses are used to seek information.	3. The doubt is not backed up by any reason from the senses.
4. This real information resolves the doubt.	4. The doubting leads into a spiral of more doubt with no new information added to help resolution.

Kieron O'Connor
 Frederic Aardema
 Marie-Claude Pélissier
 Sébastien Grenier
 Fernand-Seguin Research Centre
 Louis-H. Lafontaine Hospital
 7001 Hochelaga St.
 Montreal (Quebec) H1N 3V2
 Canada

*O'Connor K, Aardema F, Pélissier M-C: *Beyond Reasonable Doubt: Reasoning Processes in OCD and Related Disorders*. New York, Chichester: Wiley, 2005.