THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH OBSESSIVE-COMPULSIVE PATIENTS

ROSE SPIEGEL

Psychotherapy with Obsessive-Compulsive Patients

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THEORETICAL CONSIDERATIONS RELEVANT TO PSYCHOTHERAPY

Most of us have obsessional traits and lead an obsessional way of life; we are preoccupied with clock time and with problems of order and orderliness in our paper subculture. In a sublimated way, obsessional values are part of our middle-class social character. At their best, the operation of these values gets things done, particularly the routine ones, makes the world move more smoothly—so to speak, the trains run on time.

We need to understand the normal functioning on which obsessionalism is based in order to begin to understand its miscarriage in the clinical syndromes. We need to understand the traps we fall into with obsessional patients, often out of our own obsessionalism. We need to recognize banal, acceptable forms of these syndromes that yet are extremely powerful, for instance in the patient's family. These everyday aspects of obsessionalism, often ignored, should be added to our concern with the more severe and even bizarre, obsessional symptomatology.

Not surprisingly, it was the bizarre extremes of obsessive-compulsive functioning that captured the attention of the early psychiatrists, whose descriptions go back as far as 1840. A most telling and concise account is this one given in 1884—pre-psychoanalysis—by Ribot, the French psychiatrist:

> ... In works of insanity we find recorded many instances of persons who, tormented by the impulse to kill those who are dear to them, take refuge in asylums, becoming voluntary prisoners.
>
> The irresistible though conscious impulse to steal, to set fire to houses, to commit suicide by alcoholic excess, belongs in the same category. . . .
>
> The transition from the sane state to these pathologic forms is almost imperceptible. Persons that are perfectly rational experience insane impulses, but these sudden and unwanted states of consciousness are without effect, do not pass into acts, being suppressed by opposite forces, by dominant mental habit.
>
> ... Or again, a person is given to acts that though not seriously compromising are nevertheless mischievous. . . .

Sometimes fixed ideas of a character frivolous or unreasonable find lodgment in the mind, which though it deems them absurd, is powerless to prevent them from passing into acts. . . .

These disorders were placed under the rubric "diseases of the will" and, in distinction to psychotic confusion, were also designated as *folie lucide.* The feeling of being taken over by a force from within regardless of one's consciously approving will is typically the characteristic of obsessive-compulsive patients, but does not apply to the entire range of syndromes. The concept of will and willfulness is not identical with that of ego support (a theme evocative of modern views on will—Rankian and existentialist).

An Overview of Obsessionalism

As Rado pointed out, Freud's term "zwang" was translated as "obsession" in London and "compulsion" in New York. However, "compulsion" lends itself more in application to irresistibly driven behavior with some quality of impulsivity and "obsession" for preoccupation with thoughts and feelings and even for the performance of private rituals. It is as though *compulsion* has the quality of physical force.[1]

The presenting and most tangible operation in obsessional states is over-persistence in behavior, thinking or feeling or the impulse to take an action; even obsessional vacillation is persistent-experienced as subjugation to the superimposed will. However, in some individuals whom we designate as obsessional, the persistence (and/or meticulousness, frugality) has the full sanction of the ego, regardless of whether they feel themselves helpless or powerful.

More subtle and characteristic presenting cognitive operations are overconcentration with a narrowed range of thought, association and imagery with elimination of everything but what is being focused on, including the alternation of doubt. The alternations in behavior may be the well-known doing and undoing, as in the case of Freud's "Ratman," who felt compelled first to remove a stone from the road lest it hurt the lady and then to replace it, so that "her carriage might come to grief against it."

The extreme tidiness or orderliness and the fussiness with details, familiar expressions of obsessionalism, often are at the cost of loss of the larger context. In Rorschach terms, the d's and dd's (details and minutiae respectively of blot figures) are seen, but not the W's (the blot in its entirety) and often not any M's (movement perceptions). In interpersonal communication we often experience as obsessional the hammering away at a point, with a struggle to control the situation, to win, or the compulsive talker, who cannot let go of talking even at the appeal of another. The general personality quality may come across of someone on an inner treadmill, lacking spontaneity, plasticity and the freedom to change.

We are accustomed to thinking of obsessional patients as "the" obsessional character or "the" obsessional personality. This is far too simplistic. It is more accurate to think of obsessional *characteristics* which may occur in a wide range of personality configurations and psychopathology, from a richness transcending the obsessionalism to engulfment by that condition entirely within the terms of an approved social character. Besides the clinical conditions in which it dominates, obsessionalism may be involved in other psychopathologic conditions—depression, schizophrenia, addictions, the paranoid delusions, the compulsive eating of obesity or the compulsive denial of eating in anorexia nervosa. Obsessionalism is intimately connected to phobias, both in their similar tenacity and in the setting up of counterphobic rituals. There are modes in which obsessionalism operates as

an effective adaptation, as life style, even with sublimation into devoted service to a cause. It is recognizable culturally in some of the demands made on us for performance, whether in work, play or ritual.

Basic Obsessionalism

It is suggested that obsessionalism as psychopathology has its origin in a normal prototype, that it is a miscarriage of a normal capacity. The basic functioning is manifest in the tenacity and concentration that characterize the drive for mastery and accomplishment, epitomized by the child's struggle to walk in spite of repeated falls. It is involved both in self-assertiveness and in the normal aggressivity that enter into holding one's own vis-a-vis the human and nonhuman environment or of more aggressively imposing one's will on it. There is an early suggestion of this in the game of the baby who repeatedly throws out toys for the adult to retrieve. Classically, the burgeoning of obsessionalism is placed later in early childhood, at the time of toilet training and the so-called anal-erotic phase. However, the salient fact is that this is the age at which the young child can implement his will with physical as well as psychologic resources in an attempt to individuate from his mother.

Intra-psychically, as an ongoing mode of functioning beyond childhood, basic obsessionalism operates in the effort not to forget by means of an inner holding on in the mind—repeating to oneself an idea, goal, feeling. This

holding on may involve a pleasant feeling, such as a glow of accomplishment. Often it is to "unfinished business," a problem still unsolved or something immediate to be done or not forgotten, which intrudes on sleep until closure is secured. Release from this holding on may be obtained by writing out the memorandum as external reminder. However, when the achievement cannot keep pace with the aspiration, the list-making itself becomes an obsessional self-harassment. (Compulsive list-making in order not to "forget" is a symptom long familiar to physicians of hypochondriacal patients.) There is no area of experience with which obsessional concern may not be involved as a drive to problem-solving. In the field of ideas, the problem-solving preoccupation may continue into sleep and be rewarded by resolution, perhaps even by creativity.

The imposition of order belongs to the realm of normal obsessionalism. Freud, in "Civilization and Its Discontents," describes the quest for order as

> ... a kind of repetition-compulsion by which it is ordained once for all when, where, and how a thing shall be done so that on every similar occasion doubt and hesitation shall be avoided. The benefits of order are incontestable: it enables us to use space and time to the best advantage, while saving expenditure of mental energy.

We can discern here, in the quest for order, the basis for habit formation, related to the normal, basic obsessionalism. Control and orderliness of course involve time. There may be pleasure in the correlation

between accomplishment and time, as a skill in itself, a game with time. In psychopathologic obsessionalism the race with time is carried to tension and unresolved anxiety often to a freezing, a stalling of action.

Normal obsessionalism, as persistence until something is completed—as pressure for problem-solving, routinization, orderliness—involves processes that enter into the usual meaning of work. The closure by achievement re-enforces the sense of self and releases the tension of the drive to perform. In such respects, the normal prototypic obsessionalism is related to the ego functioning of mastery and the development of skills. It offers a refuge from painful emotion; one can get lost in the routine, in the effort and concentration demanded by work; one can get reassurance from the order of one's life and from a sense of accomplishment. These routines, as in work, can provide a kind of meaningful ritual. Intra-psychically, this obsessional drive to escape painful emotions forms the basis for the psychopathologic use of obsessionalism as an inadequately functioning substitute that does not achieve its goal.

A whole important area exists in which ritual and normal obsessionalism are linked through symbolism. Susanne K. Langer, in *Philosophy in a New Key,* discusses ritual from the standpoint of symbolism and its meaning, but it seems to me, she depicts the normal obsessionalism in her concept of man's need to superimpose order over chaos.

This presentation of the normal prototype for obsessionalism attempts to point out the basic functions in their own right and to indicate where their miscarriage enters into psychopathology. It is hoped that this may help in the understanding and greater ease in the actual therapy of patients who are often experienced as resistant.

Evolution of Psychoanalytic Theories on Obsessionalism

One's working hypothesis for the psychogenesis of obsessionalism may predispose the therapist to limit therapy to the terms of that hypothesis. A review of the milestones in theory should cast light on both the contribution and the limitations of their correlated therapeutic approaches.

The psychoanalytic era immediately introduced dimensions beyond the surface phenomena accurately described clinically and opened the door to far subtler observation. Freud's 1895 paper, entitled "Obsessions and Phobias: Their Psychical Mechanisms and Their Aetiology," is the entering wedge in this subject. Though there was still the simplistic one-to-one equating of disorder with symptom, the paper established that the obsessional symptom is a substitution for an "original" idea and that the substitution itself prevents release of the original associated emotion. The "original" idea of the obsession was some fairly recent, fortuitous, sexually significant experience, and "cure" was obtained by "reinstatement" of the "original" idea and its affect. In

connection with phobias, an independent syndrome—obsessional ideas and practices—served to defend against the phobic anxiety. Freud's enthusiastic efforts to "cure" obsessions by ascertaining the presumed sexual "original" idea which was being "substituted" were not effective in the long run and many years later, with broader conceptions of obsessionalism and therapy, Freud became pessimistic about the effectiveness of psychoanalysis as therapy for obsessional conditions. However, the idea of substitution and also of defense against phobic anxiety has stood the test of time.

In 1907, in "Obsessive Acts and Religion," Freud declared that both obsessional and religious ceremonials share in the objective of the warding off of fears, anxieties and guilt feelings, which in the obsessional are sexually based, whereas in religion they are based on destructive egoistic drives. Obsessional ritual, he said, is private and on the surface seems silly and devoid of meaning, whereas religious ceremonial is public and communal with rich and explicit symbolic meaning. Obsessive acts "serve important interests of the personality and . . . they give expression both to persisting impressions of previous experience and to thoughts about them which are strongly charged with affect. This they do in two ways, either by direct or by symbolic representation, so that they are to be interpreted either historically or symbolically." Freud maintained his original view that the obsessive act is based on sexual experiences. For both obsessional and religious ceremonials Freud's attribution of purpose is to the warding off of guilt feelings and not to

the expression of normal symbolization in rituals, as in Langer's discussion. Regardless of this issue or even of the therapeutic merit of this theory, in this paper Freud added another dimension, that of *meaning,* to a symptom pattern and correlated it to broader aspects of living.

In 1908, in "Character and Anal Eroticism," Freud took the first step toward understanding the obsessional personality as well as character in general. Cleanliness or orderliness, parsimoniousness and obstinacy, which have become the classical triad of the obsessional character, were linked to the presumed fixation of the libido to the anal-erotic level of development. That is, because of their rectal pleasure in retention and defiance of toilet training, Freud inferred that in these children (and adults) there is an innate constitutional predisposition to a heightened erotogenic significance of the anal zone, which is submerged in the later sublimatory triad of traits. Further he believes that reaction formation, such as generosity or over-compliance, depends on whether the "instinctual" expression or the countermanding force prevails.

Important though this paper is historically, the concept of anal-erotism, particularly in connection with obsessionalism, is disputed. Its acceptance or challenge and rejection is a good indicator of a basic difference in orientation to the therapy of patients with this condition.

In his long and labyrinthine paper of 1909, "A Case of Obsessional Neurosis," Freud gave a superb account of the psychoanalysis of a young man suffering from an extremely distressing obsessional neurosis, which included the preoccupation with cutting his throat with a razor, a neurosis which had been precipitated by some highly emotional encounters with his sadistic army captain. Interestingly, the patient had suffered from a prototype episode of obsessional preoccupation at age seven, consisting of guilty erotic wishes which had actually been provoked by his seductive young governess; fear that he might have betrayed these wishes to his parents and that they were reading his mind; fear that some disaster would occur because of these wishes—namely, his father would die. Protective measures against these preoccupations and wishes developed, which made for later episodes of variants in obsessionalism.

The interesting theoretical points that Freud made on the basis of this case gave more meaning and function to the symptomatology with implications for directions in therapy. Indeed, Freud considered that this young man had been restored to mental health. The footnote adds a timeless lament: "Like too many other young men of value and promise, he perished in the Great War."

To summarize the points he made in this paper: Freud compared the overt obsessional content with the manifest content of dreams and suggested

a similar approach to interpretation. With modifications based on different approaches to dream interpretation this is often helpful therapeutic strategy. Freud stressed that obsessionalism involves unresolved unconscious conflict between love and hate—that is, ambivalence, which with this young man involved his father and also the lady he admired. The concept of ambivalence is a revealing descriptive term, but in the writer's experience is not of itself reward in therapy unless its basis inter-personally is explored.

Freud's remarks on the cognitive processes in the obsessional combined what was already known with fresh observation and ideas of his own. He said, "The capacity for being illogical never fails to bewilder one in such highly intelligent people as obsessional neurotics." He noted the vacillation between superstition and enlightened thinking, that the former (later designated as "magical thinking") is sophisticated, taking the form of a belief in one's own dreams, hunches and intuitions as prophetic. This he considered as compensatory to the severance of causal connections between ideas and affect, particularly by displacement. The sense of the obsessional that his wishes, especially the hostile ones, can simply by their force be actualized (that is, the "omnipotence of wishes"), Freud considered a persistence of the childhood sense of omnipotence. There are, however, some analysts, including the writer, who believe that the child's sense of omnipotence is compensatory for his basic feeling of insecurity and is also partly attributable to the exaggerated response, often punishment, evoked by his behavior.

The function of the obsessional doubting, Freud said in this paper, is to render the person out of touch with reality in order to avoid a decision. His young man avoided any knowledge that would help him resolve his conflict about marriage to the lady or the lovely rich girl his mother had picked for him; what was particularly confusing to him and added to the indecision, was that his father had made the latter type of choice in his own marriage. Preoccupation with death was considered by Freud to be another device for avoidance of solution of conflict and of making decisions, covertly, death was to be the solution. By these devices, the obsessional remains incapable of coming to a decision, especially in matters of love.

Freud's next paper on obsessionalism, in 1913, entitled "The Predisposition to Obsessional Neurosis," develops the theme of the "option" of the neurosis. Freud arrived at the position that the option of the neurosis is basically derived from "the nature of dispositions" rather than from "experiences that operate pathogenically" and that these dispositions are manifest in "disturbances of development. . . . The question of what factors produce such disturbances of development. . . we must leave" to biological research. The constitutional basis here suggested introduces a climate of therapeutic pessimism. Clearly at this point the psychoanalytic schools which place far more emphasis on life experience in the shaping of personality and its disorders move away from the Freudian approach.

Freud in this paper reiterates that obsessional neurosis is based on "sadistic anal-erotism" and that in bouts of recurrent obsessionalism, regression occurs to this point in libido development.

A helpful clinical distinction is made between character development and the mechanism in neurosis—in the former, the repressed impulses are replaced by reaction formations and sublimations; in the latter, there is "miscarriage of repression and the return of the repressed." This distinction implies an explanation for the unruffled quality in the person with the obsessional character in contrast to the unease in the person with the neurosis.

A notable contribution was made by Karl Abraham within the framework of Freudian theory of libido development. He gave a rich clinical picture of obsessional questioning in his paper of 1913 on transformations of scoptophilia. He wrote extensively on the symbolic meaning of obsessional rituals. In his 1924 paper, "A Short Study of the Development of the Libido, Viewed in the Light of Mental Disorders," he demonstrated a clinical relationship between manic-depressive states, melancholia and obsessional neurosis. He drew obsessionalism and melancholia together as related to stages of anal-erotism. A particularly meaningful point directly relevant to therapy is Abraham's interpretation that in melancholia the patient is undergoing the experience of loss of the love-object, while in obsessionalism

the person is holding on tenaciously to the love-object in the face of the threatened disappearance. Abraham considered the obsessional quality that patients with melancholia have to be a manifestation of the ambivalence, the love and hate toward the lost "love" object that characterizes them.

The concept of "cure" had changed from symptom removal in the early days of psychoanalysis to the recall of infantile repression of sexuality, coupled with "insight" and symbolic interpretation, still in Freudian terms. In spite of Freudian formulations of obsessional character and obsessional neurosis in terms of sexual symbolism, classical analysis of such patients, did not achieve satisfactory results, as their therapy became obsessionally prolonged and slow moving.

A new approach to the psychoanalytic therapy of obsessional conditions —still within the framework of the libido theory—was introduced by Wilhelm Reich. In 1933, in his book *Character Analysis,* Reich presented his concept of character, resistance analysis and orgone therapy, of which the first two are within the scope of this discussion. Rather than Freud's stress on dissociation of affect from a related idea, Reich emphasized flattening of affect, "affect-block," from a more holistic view of personality. He interpreted the flattening to a persistence of extreme self-control from the time of toilet training, and appearing like the "good adjustment" that is socially acceptable. This control, he stated, is actually a repression of aggression and is manifest

in analysis as a kind of resistance which is expressed somatically in “chronic hypertonia” of the muscles. The repression, resistance and hypertonia are components of what Reich termed “character armor.” He pointed out the futility of holding the compulsive to the primary rule of free association and of offering him early interpretations, which, he held, accounted for the admittedly poor results of Freudian analysis of these patients. Instead of avoiding the resistance, he “analyzed the resistance” by means of tackling the affect-block.

His analysis of resistance involved the therapeutic strategy of focusing during sessions on verbal, tonal or bodily modes of the patient’s expression. In one example, he drew the patient’s attention to the defensiveness in his supercilious smile and his ridicule of the analyst and worked through to his recall of the early events from which his style of expression was derived. Indicative of the intensity of the resistance to free association was the patient’s reluctance to associate to his dream.

An interesting theoretical point that Reich made was that in the Freudian style of analysis, the ambivalence was not mastered and was therefore wrongly interpreted as biological instead of the outcome of experience.

In an article, “Obsessive Behavior,” Sandor Rado presented his

experience and interpretation in terms of his adaptational theory. From the cluster of elements in Freud's concept of obsessional character and anal-erotism, Rado singled out "the battle of the chamber pot" as the starting point. The prototypic experience of obsessionalism, Rado considered to take the following course: *defiant rage* at the pressure in toilet training, by which the mother makes the child feel *guilty* and implants in him the *need* for *reparative expiatory behavior*, often manifest in *obedience and compliance.* The child involved in the battle of the pot is caught between his inner need for self-assertiveness and the realization that his parent's loving care is at the price of compliance. This dilemma, of being caught between the need for self-assertiveness and the need for parental love at this price, according to Rado, accounts for the phenomenon of ambivalence and not the pull between love and hate, which is Freud's explanation of obsessional ambivalence. The maladaptation in the child's efforts to cope goes beyond repression of rage to the point of a precautionary turning of the rage against himself in the "retroflexed rage." This retroflexed rage is later manifest in the undue punitiveness and vehemence of the adult's self-reproaches.

In terms of Rado's classification, obsessionalism falls into the category of over-reactive disorder with "emergency dyscontrol." Consistent with his attempt to assimilate psychiatric syndromes to a biologic approach, Rado invoked a hypothetical genetic limitation of the capacity for genital pleasure, which, by the absence of its "power to soften rage," also contributes to the

obsessional's grimness of conscience. Though there are temperamental and constitutional differences in personality, this assumption to account for attitude or basic mood may too easily be misused by the therapist to explain away failure or the still inadequate state of our knowledge and understanding. Actually the "grimness of conscience" in both obsessional and depressive patients often does dissolve with psychotherapy.

Rado (and Sullivan in a different frame of reference) considered stammering as a speech disorder closely related to obsessionalism and based on (the assumed) "early illusion that (the) most powerful weapon is the mouth; (and) rage is channeled into speech." It is interesting that this idea of an obsessional dynamic goes beyond the narrow meaning of anal-erotism and involves the role of aggression and orality. Also recognizable is the element of the struggle for power.

The therapeutic strategy Rado devised is one application of his "reconstructive therapy," which he said required special training. In principle, first the patient is helped to break up the mechanisms of retroflexed rage and its derivatives by learning to face his full rage in recall of its original context; second, after the patient regains his composure, an exploratory analysis follows, conducted in simple terms of motivation, showing him why he behaved in the reported situation the way he did, and, by contrast, how healthy people would have behaved.

This program is patiently gone through again and again. However, Rado voiced some cautious pessimism about the results.

Karen Horney and Harry Stack Sullivan were contemporaries whose orientations overlapped, and yet they had distinctive differences. Briefly, they rejected Freud's theories of instinct, libido and character formation. Homey did not actually deal with obsessionalism in the usual sense of a dominant symptomatology or of a seeming resistance nor, as did Sullivan, in a more operational mode. In her "holistic" concept of personality she conceived of "compulsive drives" as really a quality of a whole personality and as a way of life, which in some fashion is shared by *all* neurotic individuals.

In *Our Inner Conflicts,* published in 1945, Horney presented her views on the meaning of compulsive drives, as characterizing *all* neuroses. The motor power behind the compulsivity is anxiety; the manifestations are in the neurotic craving for affection and for power and their aim is not satisfaction of needs, but a sense of safety. She also stressed that compulsive drives represent "a basic attitude toward others and the self, and a particular philosophy of life." She included indecisiveness, ineffectuality, a cutoff from the self by means of a false "idealized image" of the self, cravings for affection and for perfection, all among the characteristics of compulsivity.

In *Self-Analysis,* published in 1942, Horney had pointed out how she

analyzes a patient whose neurotic personality she interpreted as having hidden compulsive drives. We are given the picture of a young woman, Clara, which certainly is not the clearly etched obsessionalism that the other major contributors have discussed. Nor is Clara the classical obsessional personality which functions with mastery. As Horney described the movement in analysis, the trends were recognized in three phases: the discovery of her compulsive modesty; the discovery of her compulsive dependence on a partner; and finally, the discovery of her compulsive need to force others to recognize her superiority. This approach seems to be particularly applicable to the muted character of an unobtrusive but basic obsessional inhibition. Certainly Homey's approach is very idiosyncratic; we might engage in the exercise of translating her discussion into the language of the different schools of psychoanalysis.

A qualitatively new approach to obsessionalism was introduced by Harry Stack Sullivan, whose interest in obsessionalism was an outgrowth of his long concern with schizophrenia. Incidentally he expressed an admiring puzzlement at the ingenuity of obsessional defenses.

Instead of the libido theory with its concept of anal-erotism, Sullivan proposed the concept of a developmental maturation of body zones which serve as boundary with the outside world and are accessible to manipulation by others and by the individual: thus the oral, anal, urethral and genital zones.

Also, rather than a basic hostility in the obsessional, Sullivan stressed the presence of a basic anxiety evoked by specific operations within the family. As stated in *The Interpersonal Theory of Psychiatry*,

> . . . quite often an irrational and . . . emotional way in which parental authority is imposed on the child, teaches the child that the preoccupation with some particular onetime interesting and probably . . . profitable activity is very valuable to continue . . . (not) for satisfaction of new abilities but ... to ward off punishment and anxiety. When this type of performance is rewarded by approval and affection, the child's direction may well be set toward the complexity of obsessionalism.

Sullivan saw obsessionalism as a substitutive process by means of which one conceals vulnerability and anxiety and attenuates contact. This interpersonal defense shows up more often, Sullivan stated, vis-a-vis anyone with whom the obsessional integrates in intimacy. The other direction in which the defensiveness works is to keep the anxiety out of one's own awareness. The emphasis on defensive substitutions gave as one strategy of therapy the search for the hidden anxiety; sooner or later the therapist could address the patient for collaboration in this search.

Sullivan pressed the distinction between the obsessional personality and the obsessional neurosis. The former individual maintains his comfort in his mode of integrating and rarely experiences anxiety. The latter person suffers from his own obstructionism, difficulty in communication, obsessional fears of either committing violence or suicide and difficulty in achieving

closeness. The latter is the sicker person, presenting volatile challenges and varying symptomatology.

Sullivan considered some hypochondriacal obsessionalism as substitutive for schizophrenic symptomatology. He stated that some obsessional neurotics become schizophrenic, passing through to schizophrenia through the substitution of rumination for more effective adjustment. Perhaps the substitution is a defense against inordinate anxiety which would break through as panic. It is noteworthy that Sullivan's linkage of the extreme panic underlying obsessionalism with schizophrenia contrasts with Abraham's linkage of obsessional operations with the depressive syndromes. Bleuler, some years before Sullivan, had made a similar observation, but without offering any therapeutic application.

As application of the principle of the analyst as participant-observer, Sullivan noted the interpersonal interaction between the obsessional patient and himself—what the ploys were between them and what happened when he himself became caught in the patient's obsessional "flypaper." Sullivan particularly stressed the obsessional's use of language as a magical tool, stemming from the time of the child's realizing its power in the interaction with his parents, so that language began to play an even more intricate, subtle and powerful role in the tactic of the obsessional. Sullivan encouraged the patient to observe when his verbal obsessionalism became intensified and to

note any defensiveness against anxiety; he was very patient in listening to the repetitiveness for some clue of anxiety or of anxiety-laden experience, past or present, to make its appearance. He suggested that the obsessional musing about doubts and the appeal for their resolution are among the most baffling and tempting encounters for those in his environment, including often his therapist.

Sullivan handled that most distressing symptom, the obsessional fear of perpetrating violence or sexual assault, or of committing suicide, on the basis of the substitutive function of obsessionalism. In this he differed markedly from previous analysts. Rather than stress and explore the assumed (or actual) hostility in the content in a literal sense, he would state to the patient that the function of this plaguing was to distract oneself from awareness of unwelcome inner conflicts held in repression. This view, which Sullivan maintained and shared with the patient, I have found has the additional advantage of not re-enforcing the patient's sense of guilt and low self-esteem, which otherwise take on a life of their own as a problem in therapy.

Sullivan considered the ongoing obsessional ruminations to be based on a hostile interpersonal integration with a significant person in the patient's childhood with whom he had not been able to cope either interpersonally or by freeing himself inwardly, other than by the fantasy. Clinically then, this can serve as a pointer to an important relationship with someone and a mode of

interaction, which otherwise is not easily brought to light.

Reference needs to be made to Sullivan's way of handling suicidal threats made by his obsessional patients, which, he said, were "in retaliation for my alleged brutality to obsessional neurotics." He cited some biting comments he had made which had served as deterrent. Sullivan's style was coupled with an intuition which was very special and unusual. I have great reservation about taking over his mode as a routine in handling suicidal threats.

To sum up: In his explication of obsessionalism, Sullivan clearly presented first, implications of interpersonal theory both for the genesis and the therapy of a personality disorder; second, his concept of anxiety as a central issue for every personality to cope with in whatever mode of interaction he had best available—here in the obsessional mode; his eschewing of a libidinal concept of character formation.

Paradoxically, the interpersonal operations can actually be discerned in the case reports and discussions given by his predecessors, but without regard for their potency in psychopathology and for a therapeutic leverage. In contrast to Freudian thinking which placed ambivalence as the nuclear emotional state in obsessionalism and to Rado's centralization of rage, Sullivan put anxiety as the emotional state against which obsessionalism

defended.

CLINICAL CONSIDERATIONS AND TECHNIQUES

It is often remarked that since Breuer's and Freud's *Studies in Hysteria,* obsessionalism has replaced hysteria as a dominant syndrome. This has been attributed to the increasing sophistication of the culture, and with more general awareness that hysteria is a psychologic disorder, its secondary gains have diminished, whereas in social classes that have had less exposure to this general information, hysterical ailments still occur with high frequency. It is a fact that obsessionalism is a more acceptable defense to the individual and to those about him because of the logical and seemingly sensible (or more thoroughly rationalized) surface over the neuroticism. Another reason for the greater number of obsessional persons who come to therapy may be the actual intensification of obsessionalism in the culture itself. Still another factor in the actual or apparent increase may depend on the greater clinical skill in recognizing obsessionalism in its more banal form, while in the early days of the psychoanalytic era only the bizarre symptoms drove the individual to seek professional help. Finally, people nowadays have greater expectations for their gratification in living and are more likely to come to therapy seeking an answer to their discontent, whether with themselves or with the course of their lives, and not only for alleviation of specific psychiatric ailments.

In present-day psychotherapy we are most likely to encounter the *obsessional character*, the *obsessional neurosis* and also, in the course of therapy, a transitory obsessional mode of interacting with the therapist as a *form of resistance.* We are less likely to meet the patient with the *single obsessional or compulsive symptom* which seems bizarre clinically and inexplicable to the sufferer. In this group, the obsessionalism plays the central role and dominates the clinical picture. In another range of disorders, the obsessionalism is overshadowed by the encompassing condition. Such is the obsessionalism functioning as *masking syndrome* for schizophrenia or depression and in still a different way as an intrinsic part of these disorders when there is decompensation. In still another major category is the element of *compulsivity in addictions*, whether to food, alcohol or narcotics. Obsessionalism has a special and essential psychodynamic linkage with *phobic reactions.* All of these varieties have the quality of resistance.

The range of obsessional syndromes may be schematized in the following spectrum:

1. Social character and cultural pressures toward obsessionalism.

2. Normal obsessionalism. Basic obsessionalism.

3. Obsessionalism as a life style.

4. Obsessional personalities and character neuroses.

5. Syndromes of obsessional neuroses.

6. Obsessionalism and other psychopathology.

As part of or as defenses against

Depression

Schizophrenia

Phobia

Addictions

Obesity/Anorexia Nervosa

Paranoid delusions

Basic obsessionalism has already been extensively discussed and to some extent also obsessionalism in relation to both social character and life style. In this section will be presented issues and examples of the writer's direct experience in psychotherapy of patients with various syndromes of obsessionalism.

Application of Theories to Clinical Practice

How do you select from the array of theories the proper theory(ies) to apply to clinical situations? My suggestion is to center on the patient as figure-in-the-ground and to allow theories to be present but in the background of one's thinking. Without taking a polemic position nor

assuming that all theories are saying the same thing but in different words and that all therapists are functioning in the same way, we can recognize in the description of the empirical experience of the various authors of the theories one or another of our patients who at least meets one of the descriptions. The therapeutic approach recommended by the theorist remains pragmatically within the evaluation and implementation by the therapist. Every patient presents a fresh constellation of personality difficulties, assets and potential and should be viewed with freshness. How this rather open-end approach works out will be illustrated in the clinical discussion in general and specifically in the hypothesis of anal-erotism. For convenience, the different theoretical views concerning the basic psychogenesis and psychodynamics of obsessionalism are given in the following condensation:

Freud—anal-eotic libidinal fixation with sexual symbolization in the obsessional symptoms.

Abraham—(the above, plus) tenacious retention and possession of the love object in contrast to the depressive's submission to loss.

Reich—character armor.

Rado—repressed rage evoked by "the battle of the pot" superimposed on constitutionally diminished capacity for pleasure.

Homey—(not in the usual clinical phenomenology of obsessionalism, which in her special sense is based on alienation in the personality.)

Sullivan—substitution for anxiety, at times a defense against schizophrenia, with characteristic interpersonal modes of relating, including power operations in language and communication.

Clinically I have found the concept of anal-erotism only occasionally suggested in the analytic uncovering. More accurately, there were themes of preoccupation with bowel function that varied from person to person.

Two patients had parents who were obsessionally focused on stools and enemas. For one of these patients the frequent enemas became a symbol of tenderness and caring and had been experienced with rectal pleasure. The other patient became oppositional and rebellious to that particular invasiveness as well as in general and had experienced herself as helpless and powerless during the enforced procedure.

One patient was preoccupied with attempts at self-mastery and self-control, which included inhibiting his response to the signal for stool.

One patient was phobic about "germs" (the predominant symptom) and was also hypochondriacal; she was particularly anxious about breaks in control of defecation and was obsessional about cleansing herself and the bathroom.

Three patients had dreams about producing stools which were inordinately large and out of control. One of these patients was extremely fastidious as well as controlling, obsessional hypochondriacal, phobic and depressive (not the above-cited patient). Another, in her dream, was involved in an endless doing and undoing—there was the overflow and the cleaning of the toilet. In waking life, out of her low self-esteem she was often lax about personal grooming.

Some patients in their mode of behavior leave the therapist feeling affronted, "crapped upon." One such instance was reported to me of an obsessional man who had set up his private ritual of beginning his session by half-squatting and carefully emptying his pockets with a backward movement of the hands into the analyst's wastebasket. Is this a symbolic anal aggression?

Several of these instances clearly point to fixation on bowel function as the outcome of interpersonal interaction between parent and child involving the specific physical zone, as Sullivan stressed. In others, the predominant significance, not necessarily contradicting the above, was on control to symbolize a self-image of the self as dirty and to be discarded or to convey aggression. In the practice of psychotherapy, the tried and true strategy when incidents or imagery of preoccupation with bowel function are presented is to explore them for the meaning to the particular patient in his particular life experience—a principle of far wider application.

General Problems in the Psychotherapy of Obsessional Patients

At one end of the spectrum obsessionalism may be a life style with considerable effectiveness; at the other, a Sisyphus of striving and failure. Even in the extreme miscarriage of its effectiveness in agitated depression, a goal is present, generally outside the patient's awareness. It may be to express rage and destructiveness toward the one held responsible for the depression or to work out a problem in living. Getting a sense of what the objective of the operation is enhances the patient's appreciation of himself as less constricted actually than he appears.

To the stubbornness included in Freud's triad of traits, I would add the characteristic involvement with problem-solving, distorted though it often is.

It is the stubbornness and this problem-solving drive that arouse the hope of the therapist that these operations will be directed to "work" in psychotherapy. However, the patient may remain oppositional, particularly as the painful emotion of anxiety, depression, anger or even love is touched on. In defending against these feelings and also holding on to a sense of inner structure and of power vis-a-vis the other person, the obsessional operations may culminate in the impasse of resistance. Indeed, *any* inner experience may touch off defensiveness. We might say that there is a phobic flight from inner experience.

The obsessional person's alienation from his experience may actually be a restriction of articulation, a belief that feelings are not to be talked about, and at times also a lack of cognitive clarity of such processes, while the feelings are running their course. Barnett terms the obsessional's mode of experiencing affect as "affective implosion," "a mechanism by which affect is forced inward on the psychological processes and disorganizes these processes. Impression can be said to occur to the exclusion of expression."

Whatever the presenting picture, the core approaches involved getting a sense of the whole person behind the obsessional operations and ascertaining other significant pathology in connection with the function of the latter. Of parallel importance is the therapist's self-perception of his participation and countertransference.

The psychotherapy of obsessional patients requires not only the more usual modes of approach but also focuses on the obsessional operations themselves, in order to resolve them and not only move around them as obstacles. The interaction with the therapist and others is explored both for the purpose and the impact. The interpersonal bases of the defensiveness, past and present, are uncovered, as are also the emotions or affects, events, interpersonal experiences that are being substituted for. Also, the patient has the difficult task of realizing when he is being pseudo-righteous or pseudo-correct in his logic.

Focus on such operations alone can fall into the patient's sense of guilt, despair or obsessional system, making therapeutic change slow or come to a halt. A desirable complement is the cultivation of other styles of inner experience—permissiveness to self-awareness of bodily perceptions, dreams and associations to them—which leads to more spontaneity in communication.

Communication in the Therapeutic Situation

There is no royal road to resolution. One element in therapy, more than with most other categories of difficulty, is the ability of the therapist to sustain the particular kind of stress that the patient engenders without being caught in counter-obsessionalism or of snapping in irritation with the feeling

of lost self-control. A patient one can work with knowledgeably and well when one is fresh may become an irritating, frustrating challenge when one is stale and weary, and this is not a matter of liking or disliking the patient as a person. The patient's insistence that his formulations, often a priori, have right of way is particularly provocative to the therapist who is earnestly engaged in arriving at his interpretation. I recall a patient who had been self-recriminating about feeling hurt at an extreme inconvenience she had been subjected to; to my astonishment, when I pointed out that the other person had indeed been inconsiderate and that understandably she felt offended, rather than relief she felt dejected that she "could never win an argument" with me. I had thought the issue of self-esteem was involved in the *incident,* but with her, self-esteem had been involved in her *contest* with me.

Obsessional patients often appear to have steel-like durability and even the fuzzy vacillation seems peculiarly impenetrable. Yet they have unexpected fragility and may suddenly leave therapy, feeling reproached, criticized or disappointed in the absence of the covertly longed-for magic or because of an obsessional impasse between therapist and patient beyond the point of return. Spurts of mutual frustration and exasperation as well as of tedium occur in most endeavors of psychotherapy with obsessional persons, and rather than termination, these should be worked out to fuller understanding and ventilation of feeling. Rather than hostility in the full meaning of the word, the patient takes refuge in intellectual pride and dogmatic finality, with

a tinge of depressive affect, which may be the basis for stopping therapy.

The discussion has centered on the characteristic obsessional interpersonal communication between patient and therapist. Another area of communication difficulty in the therapeutic situation is the withholding of information about family and relationships that the patient thinks, or rather fears, is important to him or to the analyst. The withholding sometimes is deliberate in the game of testing the therapist's ability to "understand" him and "not his family"; sometimes it is the "forgetting" characteristic of resistance and, early in therapy, is carried almost to the point of amnesia. Even the bare externals of information are bypassed by reiteration of obsessional content, including "I don't know what to say" or "that isn't important" generalizations or pat stereotypes which for a long time the patient does not care to explore. In addition, the very quality of the family relationships out of which his obsessionalism developed lends itself to being overlooked or taken for granted. The slow, grinding, nagging control, with the premium on repression of affect and emotion, only rarely is dramatic, though dramatic occurrences also are "forgotten."

Obtaining written autobiographic details, though restricted, sometimes is helpful as a starting point. The therapist's hunch (as with the "compulsive talker" to be described) may point up a clue to a person or happening that is extremely important and encouragement to discuss more fully, or even

presenting a tentative hypothesis, may open up the area significant for the development of the syndrome. Occasionally asking, "Against whom was it necessary to (argue or . . .) in this way?" will elicit recall of the person or situation.

Cognitive Style Involved in "Magical Thinking" and Dreaming

Characteristic of the *cognitive style* of the obsessional person are "magical thinking" and/or "omnipotence of thought," often mentioned as obsessional symptoms and attributed to so-called infantile omnipotence. If the thought content is bizarre, one tends to consider a schizophrenic process as potential in the patient. For therapeutic purposes I find working with the operational role and function of this thinking pattern helpful as part of the total personality rather than focusing on it just as being of prognostic importance. The omnipotence of thought does not necessarily take on the pattern of magical thinking but rather that of responsibility for events, particularly for damaging events rather than in the open grandiosity of paranoid thinking. (This will be illustrated by a case vignette of a depressive, obsessional woman in the section, "Obsessionalism in Connection with Other Syndromes.")

It has long been recognized that the obsessional patient has difficulty in "free-associating." He may either block, be repetitive or present obsessional

ruminations as associations. Though sometimes these ruminations have the imagery suggestive of free associations, generally he is distrustful of imagery and of making contact in depth with inner experience. He generally appeals to reasoning, which may be faulty, and to pseudo common sense. A young man, who was talented in the visual arts, had had terrifying nightmares as a youngster and recent fleeting terrifying experiences of dissociation and distrusted fantasy and imagination outside his field and also spontaneity as a break in "control." Another young man, a college dropout, had recourse to intellectualizations, actually of good quality, whenever he was threatened by the rise to awareness of sexual impulses and emotions. Nitrous oxide in his dentistry was a terror because of the "loss of control."

The anxiety which may verge on terror at the break on "control" is compounded by fear of the unknown emotion behind the scenes, whether it be sexuality, aggression, love, intimacy, fear of the unstructured and whatever does not fall into the pattern of syllogistic logic or common sense; there is shame at being "caught" outside these confines.

The dream experiences and attitudes toward dreaming and associating also fall into special styles. Though no simple one-to-one correlation is offered here, I have observed the following: The dreams themselves at one extreme are just as obsessional in content as the waking verbal content and behavior with repetitiveness and prosaic symbolism. Anxiety is symbolized in some

repetitive experience. For instance, one patient's dream was of a dangerous tour through empty rooms and attics of a vast broken-down abandoned house with insecure roof beams; a woman dreamt of endless jars of preserves she was dusting and putting on shelves and also of endlessly unrolling toilet paper. A young man dreamt of moving from one scene to another on campus, where a miscellany of classmates, one after another, were doing chores such as loading trucks, from which he drove away in a new car with an advanced motor that has not yet been invented.

The meaning under the symbolic pattern of repetitiousness of the first two was despair and a dry depression at the futility of their activities. The last one, in form obsessional, turned out to deal with the young man's growing sense of power in driving away from the repetitiousness of the mundane tasks.

On the other hand, some have characteristic dreams consistently that are highly imaginative and symbolic, with the meanings obscure and the patterns not neat and quasi-realistic and prosaic. Most of the patients simply presented these dreams as enough, leaving them entirely alone or proceeding to get involved in details additively rather than getting the themes in the dream and latent content. Some worked at disowning the dream as an indulgence without much light. Many distrusted any interpretation, their own or mine, because dreams are foolish and "you can say anything about them,"

though they did not in fact come up with other associations. Some few did engage in associating and interpreting. Part of my efforts in therapy are directed to helping the patient respect his dreams and permit the play of meaning and symbolism.

It is quite clear in this section that a pervading problem in the psychotherapy of obsessional patients involves his communication and cognitive style, which is characteristic intra-psychically and interpersonally and which operates no less in the interaction between therapist and patient and as barrier to the process as "resistance." It is also indicated that every so often the therapist gets caught in both his own and the patient's obsessionalism.

Specific Obsessional Patterns and Syndromes

Patterns Involving Verbal Communication

The *compulsive talker* suffers from a dominating behavior style which actually is part of his personality as a whole and which involves speaking as part of interpersonal communication and not language per se. What these individuals present, which not all are aware of, is a competitive interrupting or drowning out of the other person by the rising din or tempo of their own speech. Not only is the voice of the other dinned out, but he is left with the sense of not hearing himself in the contest for the air waves. Sometimes the

compulsive talker does this with a speech style that is soft-spoken outside of the moments of drowning out.

I have noted that this urgency developed out of several kinds of childhood experience—namely, the child's anxious endeavor to communicate with a parent who himself is a compulsive talker; to race the parent in order to get ahead with a verbal argument; or to please a parent with achievement in language by talking in inordinate quantity (and other experiences where speech seems to be at a premium to the child).

As one patient described it, she held herself ready to pounce as her mother drew breath in talking so that *she* could get some attention for what had happened in school. What brought this woman to therapy was the effect her obsessionalism was having on the children, along with her perfectionism and taking away of their initiative.

In contrast to compulsive talking is the *obsessional blocking* in uneasy *silence.* In some instances, this is based on the following sequence of interpersonal difficulty in communication: the childhood dread that pleasing with language is impossible, because the parent never admitted an accomplishment had been achieved; the child's struggle then being expressed in the obsessional seesaw between performance and inaction, between failure and success in talking, language and thought.

Reference has already been made to stammering as an obsessional syndrome, particularly from the interpretations given by Rado and Sullivan which center around the magic and the power operation of spoken language.

Obsessional Character

Individuals of obsessional character often are fairly comfortable with themselves and turn to psychotherapy out of a general discontent with their relationships with others or because of a sense of constriction in living. At times they come motivated by the pressure of others whom they make uncomfortable. With these patients psychotherapy involves first of all helping them become aware of what operations of theirs disturb people. This awareness often is experienced with emotional detachment or as though it is the other person who has the problem of oversensitivity.

The cultivation of self-awareness includes capturing, at first fleetingly, what the flick of emotion or attitude was in the interpersonal transaction. To illustrate, the patient just referred to was actually unusually content with her life, husband, children and career and had occasional twinges of disbelief and unreality that life could be that kind to her. She came to therapy for the reason generally unacceptable to analysts that “it would make my husband happy if I cleared up a problem in communication.” This “problem” involved her endless interrupting and verbal anticipation of anyone’s talking, followed

by a shy little girl smile.

She would also try to impose her pseudo-efficient obsessional organization of time and tasks on her family—"why shouldn't he do these errands on his way to work?"

Involved in the development of her obsessionalism, in addition to communication with her mother, the compulsive talker, was also the need to prove herself "right" and clever. (Another obsessional young woman said, "Clever! That's the word!") It also was uncovered that it was important to prove herself to her older sister for whom she was almost amnestic and whose initiative and imagination she envied. Emulating her sister, she had pulled herself out of their childhood life situation of hard times and parental indifference. Her life style of drive, ingenuity and organization continued compulsively into her present-day comfort and was experienced by her husband as harassing. It was awhile before what had started out as my working hypothesis could be used by the patient and therefore was not presented until she had prepared the ground. This is another instance of the importance of the "forgotten" relative of relationship.

The therapeutic direction was as follows: first, helping her appreciate that imposing her life style on her husband disregarded his ideas and way of doing things. This then moved her to recognition that under her disarming

amiability was a competitiveness, as toward her sister. Sometime later she could become aware of the pangs of anxiety and despair she had suffered in the early days in her struggle to pull herself up by the bootstraps, which had involved the normal obsessionalism of coping.

After some months in therapy this patient was able to say, after some silence in which she became flushed and a little teary-eyed, that she was afraid that if she did not rush to say "something bright," she would find out that she was empty, that she was not as imaginative as her sister. Encouraging the patient to permit experience in its immediacy, in the moment of process, instead of outracing time and process was helpful. Later she said in enjoyment of paradox, "I am doing less and enjoying it more. Even if I do it just for myself, I don't need reasons, and before, there were reasons, even if I really made up reasons."

Some Patterns of Intimacy of Obsessional Individuals

Two obsessionals who mesh with each other in some intimacies, especially marriage, are prone to mutually lacerating experiences as one tries to impose his system on the other. Each bounds from one tangent of logic to another in arguing, the original issue is lost, there is wrangling to the bitter end in the name of principle. The amount of hostility and *ad hominem* arguing is consuming of time, ingenuity and preoccupation beyond belief. The fact

that there had been mutual attraction or that there is underlying affection is lost to recall and awareness.

In therapeutic work with couples with such interlocking problems, one of the targets is to get one or the other partner to step out of the obsessional system in addition to other approaches which are appropriate. If neither can achieve this, they may find themselves at the point of no return. The same person, living with someone who is not threatened by his obsessionalism and can stay out of it, may live in a much happier state of intimacy.

Sexual relationships are variously affected by obsessionalism, depending on the defensive function. For some obsessional persons who use their operations effectively in work or career, their sexual relationship can be immune and be experienced with enjoyment and affection. For many others, the obsessionalism invades the sexual relationship, as for example when there is a perfectionism about the "right" number of times per week for intercourse, the "right" number of times for orgasm and the interpretation of fatigue, illness or reluctance on the partner's side as being the result of either inferior performance or withholding what is due the other. Sex may be approached as a kind of work, test or performance to be accomplished, rather than as spontaneous expression or as an interpersonal experience. Obsessional preoccupation or little chores that just must be done around the time of intercourse often interfere with emotional and physical closeness.

One mode of relating of obsessional persons is in the "love-hate ambivalence," which mainly appears as a stark inner contradiction, the peculiar distinction of these individuals. However, on closer and more discerning view of the intimacy of "love-hate" is a dynamic flux, an intricate sequence of phases, which then recycles as follows: the brief "honeymoon" of love and acceptance; accumulation of stress from "intolerable" faults and frictions; mutually lacerating criticism, rejection or withdrawal; fleeting relief from tension with subsidence of the obsessional mode of operating; depression at the loss of the "love-object" (regardless of the basis); the quest for him; coming together afresh with the emotionality that initially bonded them; the beginning of the obsessional interaction—and the cycle resumes.

The cycle may be condensed into a very short span of time, in "love" and out in a few days, or take about six months. The repetitions may characterize the course of a longstanding marriage, indeed provide the excitement if the marriage goes on; they may finally just break up the intimacy and change partners. In several couples I have had the opportunity to study, there were indeed facts which made for the attraction and others which could be distressing, if the partner was going to be intolerant and unaccepting. At times what was more important than affection was the feeling of power or its pursuit. One element in the coming together after the pulling apart is the fear of loss of the love-object, reminiscent of Abraham's description of the tenacity of the obsessional in contrast to the relinquishing of the depressive.

This discussion is offered to be suggestive and to leave the subject of ambivalence open ended and also to exemplify the interplay of theory and clinical observation, which may give correlations that were not necessarily predictable.

Obsessional Neuroses

In the person with the obsessional neurosis we are faced with a different order of difficulty from that in the obsessional personality. The contrast hinges on the ego strength of the whole personality and on both the intrapsychic role and the interpersonal use of the obsessionalism. In the obsessional neurosis the person feels himself harassed by himself and by the demands on his attention made by the compelling symptom and not by the other person. He has a quality of ineffectuality and of poor ego strength and feels himself inadequate—that *he* is failing and not that the other person is failing him. He may consciously experience diffuse anxiety as well as the obsessional symptom that partially defends against it. The persistent repetitive thought does not make sense to him. The repetitive doubts or self-questioning are undiminished by either his own repetitive answer or the common-sensical ones offered by others to allay his distress. The compulsive bit of behavior may make sense to him the first time around, but it is the repetitiveness that does not and which is disquieting.

The specific dominating obsession is the top of the iceberg of an obsessional personality, and psychotherapy involves the dimension of working with the person as a whole, beyond the single-minded confrontation with the presenting obsession.

Understandably the therapist as well as the patient is puzzled and seeks the meaning of the obsession itself, as in the classical paradigm that Lady Macbeth's handwashing is to wash out her guilt. Clinically, however, ascertaining the symbolic meaning does not relieve the obsessional operation, or it may be used to exchange another operation for the early one. That is, to the obsessional person, the formulation of the meaning of the obsession falls into the obsessional system; as it were, it embellishes the system and is not experienced in terms of the therapist's intent. The so-called insight, chalked up as a failure of true insight, actually had not revealed in depth what the obsession was substituting for. Reassurance for the associated sense of guilt also gives only fleeting comfort.

After giving us a chance at the direct examination of the obsession, I have found it productive to move on to the uncovering of the patient's life, in the broad design of psychoanalysis but with specific modifications for obsessionals. To recapitulate, there should be much more activity on the part of the therapist to involve the patient outside his reiterated obsession by asking him to describe current interpersonal experience, past experience,

moods and emotions and thoughts other than the obsessive ruminations, difficult though this may be. Also—though this cannot always be maintained—stay out of hassles with him. Re-enforcement of the expression of any feeling, regardless of whether it specifically underlies the obsession, encourages a widening of such experiences.

These patients often try to impose their obsessional rules on the therapist. Examples may be "urgent" phone calls of crises that are not even mentioned the next session, letters of explanation as running supplement to the sessions or peculiar ways of paying bills (one man had a routine of emptying his pockets into the analyst's wastebasket at the beginning of every session). These foibles, often with a pseudo-sensible facade, may be tolerated long enough to recognize them and then it is effective to pull out from being subject to the system.

The following thumbnail sketch will illustrate some of the points about therapy.

> A youth had an obsession based on a sexual advance to a girl, which was the reiteration: "I shouldn't have said 'suck.' I said it and that's why I am sick!" He also was depressed and had brought his life to a standstill. His verbal productions were sparse and consisted essentially of the obsessional reiteration and a plea to be made happy. He wrote me, "Would I have developed an obsess (sic), if I had said, 'would you like to perform fellatio?' do you think? . . . are my obsessions irrational in the sense that they do not relate directly to the depression. In other words is it correct that the obsessions are not normal?"—formulations whose meaning is

befuddled.

> The acknowledged turning point in getting out of his minute obsessional orbit was the growing awareness of emotion that emerged in response to the approach I have described. His frustration, anger and rage with the girl became more open. The girl he "liked" did not meet his standards of status. He had selected her for his initiation into sex, and her lack of acceptance precipitated in him both rage and a sense of inadequacy that even someone "not worthwhile" rejected him. He then entered a phase of flaring up angrily and lustily at mild provocation—from other drivers, his parents, myself. In addition, participation in group therapy with his age peers helped mobilize him.

This case vignette is also noteworthy for the presence of severe obsessionalism in the encompassing depressive syndrome.

Obsessionalism in Connection with Other Syndromes

Phobias. The phobias themselves have an obsessional tenacity coupled with intense anxiety, but they also alternate with the obsessional counterphobic ritual of control. The phobia is comparable to the specific obsessional symptom in the obsessional neurosis, though it is associated with a far greater intensity of anxiety in awareness. Comparably, the phobia has its immediate symbolic meaning which accompanies the anxiety experience, and ascertaining this meaning has only a limited therapeutic usefulness, in contrast to ascertaining the broader underlying significance. For instance, in the case of a young woman whose activity was severely restricted by a phobic anxiety about germs and by a counterphobic obsessionalism about sterilizing,

the phobia and the obsessionalism turned out to be substitutions for a rageful killing off of human "enemies" with whom she felt powerless and inarticulate. The direction of therapy then was to help her in her self-assertiveness and the awareness of anger, so as to diminish the necessity for displacement.

The meanings of the phobia and obsessionalism emerged indirectly after attempts to reach it directly had failed. The clue was given seemingly in an unrelated way by my growing awareness that any comment I offered to her request—whether to help her cope with a life situation, understand a relationship or penetrate to the meaning of her distressing symptoms—was dinned out. Then it was established that accompanying the pseudo-reasonable questions and challenges she presented me with was the feeling "she thinks she knows it all and that I know nothing" and a determination not to be overridden. Thereby the greater my earnest efforts, the greater her countering.

This partial insight, which of itself resolved nothing, opened up her awareness of rage at me which gave more vigor to her cleansing obsession immediately after a session. The transferential basis lay in her impotent rage at each member of her family who had tried to "improve" her, to give her "advantages" in order to compensate for a congenital defect. Further exploration disclosed her sense of power in killing "germs" as symbolic of the rageful destruction of human "enemies" with whom she felt powerless and

inarticulate. The direction of therapy was to have her accept the confrontation and to develop the courage involved in becoming more self-assertive, to become aware of her anger and what precipitated it, in order to diminish the necessity for displacement.[2]

SCHIZOPHRENIA AND DEPRESSION. Obsessionalism functions in various ways in the context of schizophrenia and depression, indicative of the complexity of the constellation of processes that give it its character and also linked to the particular state of integration or decompensation in these particular conditions. Obsessionalism may be an intrinsic part of the disorder and operate *within* it; it may be part of the decompensation, a defense against it or a masking syndrome.

As part of the schizophrenic process, the tenacity with which a stereotype of language, gesture or ritual is maintained meets the criteria for obsessionalism or persistence, substitution and/or symbolic meaning. As an example, a schizophrenic youth's monotonous repetition of "I have a vagina" led to the disclosure of its meaning, which was not what we would tend to assume—namely, loss by castration—but his longing for a vagina as belonging to the favored sex, as did his sister, his mother's favorite. Similarly the paranoid delusion in schizophrenia is characterized by tenacity and substitution, but the bizarrete and grandiosity, the open pleasure and sense of power, contrast with the sense of guilt that characterizes the obsessional.

As part of the depressive process, in agitated depression, the obsessional preoccupation and utterances circumscribe the individual in every avenue of functioning; they prevent him from making full emotional contact with his world and from cohesive efforts; they set up formidable barriers to communication, including being reached by the therapist. The schizophrenic obsessive idea is more likely to be bizarre while the depressive thought is most often a declaration of self-reproach or reproach to others and of pessimism and hopelessness backed by pseudo-logic. Reference has already been made to the type of magical thinking entering into the obsessionalism which is part of depression.

The following is an illustrative case vignette:

> One patient, a chubby little woman of fifty, with bouts of depression beginning with her second pregnancy and with obsessional self-berating for the low stature of her middle son and the allergies of the two others, blames herself for having read and acted upon dietary experiments on rats in the feeding of her infant sons. There is denial that any hereditary factor about stature may apply. Her refusal to accept any assuagement of presumed responsibility for damage is defended with obsessional intensity of arguing. Her description of longstanding ineffectual efforts to please her mother and a critical, dogmatic older sister suggests a linkage with her inordinate disappointment in her son and her inordinate sense of the power to damage. At least she is distinguished by a negative monument of low self-esteem. Though this is the translation of the meaning of her sense of guilt and self-berating, to use this directly in therapy is ineffectual. The larger scope of the underlying psychodynamics for the obsessional omnipotence for damage and for the recurrent depressions involves far more than the meaning factor and includes her ambivalent competition not only with the sister but with intellectual

> authority in general and her sense of having some power, even if it is hidden and negative. It is noteworthy that what had appeared as a mysterious omnipotence of thought in the patient's wording in the first session began to lose its quality of mystery and of bizarrete as these various factors were disclosed.

There is one special connection between obsessionalism and depression —the obsessive's constriction of experience leaves the person with the sense of ego diminution which contributes to a feeling of depression; so does the sense of failure when the individual cannot achieve his obsessional goals.

In both *schizophrenia* and *depression,* the *masking obsessionalism* serves as an integrative defense in that it gives a sense of self-control, power and coping vis-a-vis the outside world. In the schizophrenic masking, the protective obsessionalism is the great emphasis on reasoning and logic to prevent immersion in fantasy and the autistic world.

In the depressive masking there is frequently routinized compulsive action designed, often consciously, to combat the inertia of depression. In both these compensatory uses of obsessionalism, a fairly well-functioning adaptational goal for maintaining the integrity of the psyche is achieved, but this often is at the cost of not resolving the underlying or latent disturbance. An example is the flight into an obsessional type of working and into frenzied smoking of a business executive who admitted he did not dare face the depression of impending retirement. Particularly in men with the cultural

value of pride in work, obsessionalism is used as a mask in a flight from therapy.

Where one has reason to believe that the obsessionalism is a mask for depression or schizophrenia, one should be prepared to cope with the undefended pathology disclosed. This then is a matter of therapy of the underlying schizophrenia or depression. Whether it is more therapeutic to work toward removing the mask or toward helping the individual build some inner strength before challenging the serviceable defense must be determined with each patient. We are really concerned here with the therapy of the underlying condition rather than of the obsessionalism. The same problem applies to the addictions in which also an obsessional style is present as part of a complexity of factors beyond the scope of this chapter.

Obsessionalism ranges from normal functioning and mastery through a variety of miscarried effort and aggression involving thought, language and feeling. Into its understanding and treatment have entered trial, error and achievement from the various psychoanalytic approaches.

Notes

1 The writer, in general, uses “obsessionalism” to signify “obsessional states” (Sullivan’s term), “obsession” for the particular pattern and “compulsive” for the drive to an action.

2 For a general discussion of phobias, see Freud’s "Predisposition to obsessional neurosis.

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