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OBSESSIVE BEHAVIOR

Integration of Psychoanalytic and Other Approaches

RUSSELL R. MONROE

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Table of Contents

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Phenomenological (Existential) Model

In Part A of this chapter, Rado lucidly reported the Freudian description of obsessive behavior, as well as the post-Freudian adaptational psychodynamic explanation for the development of obsessive traits and obsessive attacks. The other significant framework within which obsessive behavior has been described is that of the phenomenological or existential analysis as elaborated in the writings of Jaspers, Straus, and von Gebsattel. The fundamental prerequisite of a phenomenological analysis of obsessive behavior is to clear one's mind of preconceptions of both clinical descriptive psychiatry as well as psychoanalytic theory. In this sense, then, phenomenological analysis is the radical empiricism of observing overt behavior without either concern for biographical data or reliance on a motivational analysis of behavior (psychodynamics), with its assumption of unconscious mental activity. The phenomenologists insist upon this because a biographical report is data only in the sense that it is the individual's memory of his past and not the situation as it actually occurred; hence it has little

explanatory reliability in determining etiologic mechanisms Phenomenologists also believe that inferences regarding the unconscious more likely reflect the thoughts of the observer than the observed; thus, there is the danger of forcing data into the mold of old hypotheses, rather than developing new ones to fit the facts.

The psychoanalyst answers that the phenomenologist's radical empiricism seeks for an illusory intellectual security in restricting extrapolations to the domain of the thoroughly tested, without taking the risk of hypothesis formation and future-testing. Despite this avowed difference in observational attitudes, the conclusions arrived at by both the phenomenologists and psychoanalysts, such as Rado, are surprisingly similar. Perhaps this is so because both are rigorous observers of clinical behavior. Some "pure" phenomenologists, however, question whether morbid attitudes or psychopathology is a proper field of inquiry for their study, because phenomenology depends upon the "verdict of immediate experience," which suggests that the only legitimate areas for phenomenological analysis are such universals as consciousness, anxiety, volition, etc., and not the unique or deviant phenomenon represented by psychopathology, which precisely because of its uniqueness is not a universally immediate experience.

Jaspers treats this dilemma by analyzing the morbid experiences in comparison to the non-morbid or universal experience. From his analysis, we

can identify five essential characteristics of compulsive symptoms: (1) a nonsensical, meaningless, or absurd quality to the thoughts and actions of the obsessive, which is recognized by the obsessive himself; (2) despite this recognition of the meaningless quality of the symptoms, the thoughts and acts have a compelling force; (3) a belief that thoughts and actions can influence events in some magical, omnipotent way; (4) a need for certitude and order associated with a brooding doubt; (5) a preoccupation with terrifying, unacceptable impulses usually of an aggressive nature; that is, the patient fears he will harm someone else or be harmed himself. There is no essential difference, therefore, between the phenomenologist's description of the obsessive, and Freud's original description quoted by Rado.

After description, however, the next steps are quite different in the phenomenologic and the classical psychoanalytic models. For instance, within the libido theory, the ultimate explanation of obsessive behavior is that the obsessive individual has regressed to the anal sadistic level of libidinal organization and therefore is not solving his oedipal conflict with phallic gratification, but utilizing punitive and expiatory symptoms because of his sadistic superego. In a somewhat more elaborate statement, Anna Freud says that obsessional neurosis in children closely resembles its adult counterpart; she then explains the development of the obsessional neurosis within the libido framework:

> [There is] initial developmental progress to a comparatively high level of drive and ego development (i.e., for the child to the phallic-oedipal, for the adult to the genital level); an intolerable increase of anxiety or frustration on this position (for the child castration anxiety within the Oedipus complex); regression from age-adequate drive position to pregenital fixation points; emergence of infantile pregenital sexual aggressive impulses, wishes, and fantasies; anxiety and guilt with regard to these, mobilizing defense reactions on the part of the ego under the influence of the superego; defense activity leading to compromise formation; resulting character disorders or neurotic symptoms which are determined in their details by the level of the fixation points to which regression has taken place; by the content of rejected impulses and fantasies, and by the choice of the particular defense mechanisms which are being used.

These defense mechanisms in terms of the psychoanalytic ego psychology are displacement, reaction formation, isolation, and undoing, together with the excessive use of intellectualization, rationalization, and denial. Many feel that such "explanations" within the libido framework are not truly explanations, but tautologies, understandable only to those steeped in psychoanalytic language, and, in fact, not even of much use to the psychoanalyst. The complexities of such theoretical considerations are illustrated in two psychoanalytic symposia on the subject.

Rado's motivational analysis proposes that obsessive behavior develops from conflicts between the child's defiant rage and fearful obedience in a struggle with parents who attempt to control the child's rages and fears in order to make him fit for a civilized society. If this training proves successful, it teaches self-control and cooperativeness; but if unsuccessful, the child

responds with either defiant rebelliousness or fearful submission, reinforced by an omnipotent belief of inescapable punishment. This is to Rado the essence of obsessive behavior.

On the other hand, the phenomenologist investigates the obsessive's versus the normal's view of the world, and establishes how this view influences their "I-world" relationships. Thus, the phenomenologist looks at what makes the world nonsensical, meaningless, or absurd to the obsessive, what gives this view a compelling force, and how his belief that thoughts and actions have a magical omnipotence arises. In doing this, Straus feels that most obsessives belong in one of two groups: those with what he calls "contamination obsessions," or those who fear they are "compulsive" killers. Those with "contamination obsessions," Straus says, have no feelings of abundance, harmony, softness, growth, vigor, beauty, or love, as found in the normal individual; the physiognomy of their I-world relationship is completely reversed from the living to the dying, from the blooming to the failing, from abundance to scarcity, from vigor to apathy, from appetite to disgust. The world becomes decay in a thousand shapes: disease, dirt, decomposition, germs, dust, mud, excrement, sweat, sperm, sputum. Straus identifies the central theme as a feeling of disgust and decay, and analyzes these feelings in terms of the normal's view of the world. He points out that what is disgusting to the obsessive may also be disgusting to the normal in certain contexts:

> The sweat of the athlete who has just won the contest will not prevent his girlfriend from embracing him, the perspiration which covers the face of the sick has quite another effect; the difference is determined by the context to which the parts belong.

In the first instance, the context is strong, healthy life; in the latter instance, it is sickness and death. Thus, the sick or weak man is disgusted by a plate heaped high with delicious food, as may be the normal person whose appetite is satiated, but not the person who is hungry and healthy. Straus sees the "sympathetic relations" of the contamination obsessives as limited and feels that the contamination obsession is psychotic behavior with an inherent genetic deficit of sympathetic, abundant, warm, loving feelings. This is similar to Rado's conclusion from his motivational psychodynamic analysis, that there is a lack of pleasurable emotions in the obsessive's life. In summary, Straus says that the world in which the contamination obsessives live is such that their behavior is dominated by horror and dread, not because of fear of imminent death, but because of the presence of death in the sensory immediateness, which is warded off by the feelings of disgust.

Concerning the obsessive "killer," Straus believes their symptoms are characteristic of the neurotic obsessional. Briefly summarized, the perfectionism of the obsessive serves to overcome his paralysis of action; that is, "Perfectibility alone permits action, for only if something were perfect would it be immune against attack." Likewise, in his orderliness the obsessive defends himself in a struggle against omnipresent attacks, just as he uses

isolation to avoid struggle with the hostile world. The ritual represents a primitive magic by which the obsessive protects himself against this hostile world, where, helpless and alone, he hopes that the magic of repetitious acts, that is, the ritual, will protect him from aggression. Straus, then, offers an answer to the problem of distinguishing the neurotic obsessive from the schizophrenic patient with obsessional symptoms, a distinction important for both prognostic and therapeutic reasons. However, I know of no follow-up study which substantiates Straus's impression that the contamination obsessions are always or even usually schizophrenic, although clinical experience suggests such a possibility.

The deficiency in the phenomenological model is that although it may help us understand the world view of the obsessive, it does little to explain it, nor does it clearly identify a course of corrective action to either prevent or modify obsessive behavior. Psychoanalytic theory would predict that obsessive parents will likely rear obsessive children, and this certainly is supported by clinical observations. Nevertheless, the psychodynamic model is not a sufficient explanation, because children reared in the same predisposing environment with obsessive parents do not invariably develop obsessive neurosis or even obsessive traits. By and large, investigators in the field of psychopathology have committed themselves to either the psychoanalytic (psychodynamic) model or the phenomenological model. Both models, however, leave the student with a feeling that there is still much to be learned

about obsessive behavior.

There is an obvious alternative to this dichotomy; that is, perhaps psychodynamic and phenomenologic methods are complimentary; an integration of the two might shed light on the development of obsessive behavior, which, in turn, might provide clues as to how such behavior can be prevented or modified. An attempt at such an integrated analysis follows.

Rado states that one is predisposed to obsessive behavior if there is a stronger than average residue of primordial omnipotence (primary narcissism), and a deficiency in the usual pleasurable emotions that would otherwise counteract intense emergency feelings, such as fear and anger. In another context, Rado points out that the basic emergency emotions of fear and anger are inevitably associated; usually one is more obvious, but the other is present, even if covert. Others- modify this concept by adding that the truly significant factor in the development of the obsessive is that neither fear nor anger dominates the other, although both are excessive. Each affect, that is, fear and anger, is felt and overtly responded to simultaneously or in rapid succession. The result is a constant vacillation between polar opposites of fear-dominated obedient behavior and anger-dominated coercive behavior. MacKinnon and Michels described this succinctly:

> The obsessive individual is involved in a conflict between obedience and defiance. It is as though he constantly asks himself, “Shall I be good or may I be naughty?” This leads to a continuing alternation between the emotions

> of fear and rage. Fear that he will be caught at his naughtiness and punished for it, rage at relinquishing his desires and submitting to authority. The fear stemming from defiance leads to obedience, while the rage derived from obedience leads back again to defiance.

This formulation is supported by the clinical observation that if anger comes to dominate the obsessive's behavior he develops paranoid, referential, persecutory behavior, while if fear dominates he is more likely to develop a depression with guilty protests of unworthiness as expiatory attempts to recapture love. A dramatic example of this fear-anger conflict is illustrated in the following treatment situation:

An obsessive patient in analysis had only two rules to follow. One was that he come regularly to his appointment five times a week, and the other that he report as candidly as possible all thoughts that came to his mind, no matter how irrelevant they seemed, or how difficult they were to reveal. As might be expected of the obsessive, for two years he was prompt for appointments and seldom missed one for any reason. However, there were long silences during which the patient admitted to many thoughts which he deemed irrelevant or unimportant, hence would not report. Despite repeated interpretation of this resistance to therapy, he entered a phase in treatment where for eleven successive sessions he came promptly, left promptly, but during the hour did not say a word. His therapist, too, remained silent. At the twelfth session, the patient finally blurted out in frustration the absurdity of his behavior; that is, coming regularly, yet sitting a full hour in silence. He

spontaneously recognized that attending regularly was his obsequious, obedient attitude, but refusing to communicate in these sessions represented his angry, rebellious behavior.

It is easy to understand how the constant vacillation between fear-dominant and anger-dominant behavior leads to the bizarre inconsistencies in the life patterns of the obsessive. We can also realize his consequent need for certitude and order, associated with brooding doubt. However, motivational analysis does not explain the nonsensical meaninglessness of the obsessive behavior. Perhaps a phenomenological analysis will help in understanding at least the neurotic obsessional patient, that is, the patient Straus calls the obsessive "killer." Dynamically we can understand from where fear and anger arise, but we cannot understand the affects themselves, which requires a phenomenological analysis.

Much is written in the existential literature concerning fear and dread, but surprisingly little about rage and anger. Space only allows a cursory phenomenological analysis of these affects. Pertinent to our considerations is Heidegger's concept of *Angst,* translated in the existential literature as "dread," and distinguished from fear. Heidegger used the word fear in the sense of being afraid about something or afraid of something; that is, the fearful man is "always bound by the thing he is afraid of and in his efforts to save himself from this something, he becomes uncertain in his relationship to

other things. In fact he loses his bearing generally." On the other hand, dread is always a dreadful feeling about something vague, but not about a specific thing or a specific person. The feeling of dread has something uncanny about it, it crowds around us, leaves nothing for us to hold on to, and in fact is the ground of our very being and reveals the existential concept of "Nothing." This dread cannot be denied or avoided, except through neurotic behavior. This all-pervasive dread sometimes is described as "spellbound peace" or "blissful" peace. The continuity of these apparent polar opposites is hard to understand, but can be experienced in the "peak" experience (psychedelic or religious experience). To Heidegger, this dread was the very ground of our Being. Although it is an oversimplification, we can say that not accepting this dread distorts our Being. Could it be that this very lack of what Straus calls "sympathetic emotions," or what Rado says is a deficiency of pleasurable emotions, that is, the feelings of abundance, warmth, understanding, growth, etc., denies the association between dread and blissful peace, leaving this basic human emotional tone unacceptable to the obsessive? The dread then is shifted to fear; that is, afraid about something or afraid of something. Thus, the obsessive, as Heidegger says, becomes uncertain in his relationship to other things.

There is surprisingly little written about the competing emotions of rage, hate, anger, and resentment. Boss, however, identifies anger and rage as affects, hate not an affect but rather a passion; both he calls emotions. To

paraphrase, he says that we cannot decide and undertake to have a fit of anger. It assaults us, falls upon us, and affects us suddenly and tempestuously. Anger rouses us up, lifts us above ourselves in such a way that we are no longer in control of ourselves. We say of someone who is in a fit of anger, "He is not really himself." The passion of hate also cannot be produced by decision. Like an affect, it, too, seems to fall upon us suddenly. Nevertheless, the assault of the passion hate is essentially different from the fit of anger. It can break out suddenly in deed or utterance, but only because it has long been rising within us. It has, as we say, been nourished within us.

On the other hand, we do not say and never believe that anger, for example, is being nourished, while a passion such as hate is. A fit of anger, on the other hand, subsides again as fast as it comes over us—it blows over. Hatred does not blow over; after its outbreak, it grows and hardens, eats into, and devours our entire feelings. This collectiveness of our being, brought about by the passion of hate, does not close us off, does not blind us (like the affect anger), but makes us see more clearly, makes us deliberate. The angry man loses his senses, the hating man's senses are heightened. The great hatred of the paranoiac, for instance, makes him aware of the slightest traces of hostility in his fellow human beings. Anger is blind, while a passion such as hate heightens one's being and opens one up to the world. It is rare that the obsessive becomes enraged, just as it is rare that he panics, but he is constantly fearful and simultaneously persistently hateful or resentful.

Perhaps it is not only the lack of pleasure that augments the intensity of fear and hate, but also the fact that the obsessive seldom allows himself to become enraged or panicky, which, in turn, would allow the affect to "blow over" and dissipate the passion, which otherwise is nurtured and persists. As Boss suggests, then, the passion hate concentrates and extends the obsessive's view of the world, even if it narrows his field of vision. The obsessive's cognitive and behavioral deviations defend him against the subjective awareness of this hate, but his concentrated view of the world gives malevolent meaning to even the most extraneous circumstances. As Heidegger says, "It goes without saying that this collecting moves in a direction which depends upon the passions by which it is brought about." To repeat, then, the intensity of the passion hate becomes particularly obvious when the obsessive's defenses against the passion are thwarted, or release through anger or inhibited panic.

What are the further implications if the obsessive's view of the world is concentrated and directed by the basic passions of hate and fear, neither being attenuated nor counteracted by the passions of love, nor dissipated by a "fit of anger or panic"? What does this do to the illumination of the world as seen by the obsessive? If the world is illuminated solely by the passions of fear and hate, with no counteracting feelings of love, joy, abundance, growth, it is a world of malevolent forces filled with decay, contamination, persecution, and killing. Because of the vacillation between fear-dominated

and hate-dominated passions, one moment the obsessive is the victim of these malevolent forces, and the next the instigator, one minute fearfully obedient, and the next angrily coercive, one moment killed, the next the killer.

Does an analysis of the effects of these passions clarify other obsessive symptoms, such as the nonsensical, meaningless, and absurd nature of the obsessive behavior? To examine this we have to understand what we mean by meaning or what makes something nonsensical. (Here, we give credit to Strasser for his lucid discussion on the subject.) Meaning, even in the practical sense, is always the meaning of Being, and one makes this Being visible by discovering it through one's actions. While this is an intentional achievement, the intentions in themselves are not creative. Nevertheless, a discovered object owes its Being for me to my "dis-covering" acts. For example, the meaning of a glass of ice water in front of me becomes clear as I reach for it on a hot summer day and lift it to my parched lips. What would happen then if my intentions were contradictory? If, for example, I make contradictory judgments concerning Being, as revealed through intentions which were in turn contradictory. If my intentional acts are vacillating, with the vacillating basic passions of fear and hate, then everything would be nonsense, as a result of this defective intentional achievement. The discovered object is one minute this, the next that, with "this" and "that" usually at polar extremes; hence, the nonsensical nature of my behavior and the meaninglessness of the world about me. For example, in my fear-dominated intentional act, the glass

is filled with tepid, cloudy, contaminated water, or in my rage-dominated act picking up the glass is to throw it in the face of my host who has humiliated me; there would be no gratification, no clarity, no consistency in my intentional behavior, therefore, the world becomes meaningless and my actions inconsistent and nonsensical.

As we establish meaning through our intentional acts, the horizons of our knowledge extend and that which was previously beyond this horizon (i.e., not previously experienced as an object of our intentional acts) loses its meaninglessness. We know, however, that we cannot encompass the whole in its entirety; that is, there will always be a horizon or a limit to our consciousness (a world filled with potential intentional but not yet consummated acts). Even though we do not yet know the meaning of that which is beyond the horizon, we do not assume it is nonsense, but believe it could become meaningful through intentional acts, once they occurred. However, if our intentional acts are always contradictory, then this world beyond our horizon is likewise contradictory; that is, nonsense, mysterious, unpredictable, and threatening. To elaborate further, if we could ascend to the heights of a transcendent cognitive attitude, that which has become meaningful for us through our intentional acts might be compared by analogy to a mere nutshell floating on a fathomless and tumultuous sea. But this tumultuous sea, still meaningless to us, is not empty of meaning. It has a still hidden and unspoken meaning which Strasser refers to as “premeaning” or

“fundamental meaning,” in contradistinction to the “signified” meaning which has already revealed itself through our discovering acts. There is an element of dread in this vague premeaning, which seems to be a basic human condition. Those who cannot accept this dread, according to Tillich, deny this mystery by substituting a false certitude, often in the form of neurotic, particularly obsessive, behavior. The obsessional individual refuses to accept the mystery of this ontological truth. Others see this mystery in terms of growth, abundance, and becoming, but the obsessive, in his vacillation between fear and hate, sees it only as malevolent and leading to death, destruction, decay, and disease. With this view of the world, it is not surprising that the obsessive has an intolerance for the indefinite, undetermined character of what is beyond the horizon and still beyond his intentional acts. He denies this mystery and, instead, fills his world with intentional acts that become increasingly mundane, repetitive, routine, and nonsensical. He hopes to control the mystery which he cannot face through the magic of rituals. Thus, in order to avoid the unknown, the complexities of the world are made certitudes by precise intellectualizations, rationalizations, and simplified causes and effects, while the mysteries of the premeaning beyond the horizon are made certitudes through the concretization of magic. The obsessive then fills up his world with trivial intentional acts; the frightening void of the unknown becomes a meaningless known of mundane activities. If this sounds too metaphysical, remember that the obsessive is

preoccupied with metaphysics. Support for such metaphysical ruminations seems to lie in the surprising similarity of obsessives' rituals, regardless of culture and developmental background. This strongly suggests that the obsessive's behavior might be more than that which Rado proposes, namely, a displacement of the overly strict morality of the nursery which, in turn, leaves an overly strict infantile superego.

Finally, we must consider the obsessive's sense of omnipotence. This omnipotence pervades not only normal behavior but also many pathological states. Primary omnipotence (primary narcissism) is inferred from the behavior of the very young infant and reaches its peak of absurdity in the grandiose delusions of the paranoid. Omnipotence is adaptive when it provides a necessary security during periods of relative helplessness, with survival depending not on an individual's efforts, but on fortuitous circumstances beyond his control. The sailor, when washed overboard, swims aimlessly, convinced that death will pass him by and rescue is imminent. Returning to the analogy of the meaningful world as a mere nutshell on the fathomless sea, we can see how dread of the ontological mystery can also be relieved through a personal sense of omnipotence. Such a sense of omnipotence not only has healing value, but is essential in viewing the "totality-of-what-is." Only through this sense of omnipotence can we be aware of the infinite, the perfect, pure actuality, as opposed to the frightening and unpredictable potentiality. Painful renunciation of this omnipotence,

however, is part of human maturation, apparently made easier by the perception of love, abundance, and growth, all of which imply a benevolent fate. If the obsessive sees only destruction and disintegration, then maintaining one's personal omnipotence is the only defense for such a terrifying world, giving one power to coercively control the destructive fates through even more powerful personal magic. The fact that the obsessive's magic rituals are unceasing and only temporarily relieve anxiety indicates that unlike the grandiose paranoid individual, he has no real conviction of his personal omnipotence, only hopes for it, while fearing that if he does not possess it someone else does.

The vacillation between angry coerciveness and fearful submission leaves a pervading sense of inconsistency and confusion in the obsessive's view of the world. There is no stable ground phenomenon upon which he stands. The obsessive drives unceasingly to the point of exhaustion to find a secure foothold. Decisive action becomes more and more trivial, totally lacking in adaptive value, but quite cogently reflecting the need to find consistency in a world illuminated by the conflicting and threatening passions of fear and hate.

Thus, it seems that after identifying through a motivational analysis the conflicting passions of fear and hate, neither counteracted by pleasurable emotions, further explanation for the obsessive's behavior can be sought by a

phenomenological analysis of the basic passions fear and hate. Then, what is poorly explained by psychodynamics, that is, the nonsensical quality of the obsessive's behavior, as well as his tireless struggle for meaning and his need for magical omnipotence, becomes clear.

Differential Diagnosis

Obsessive Neuroses

The most widely accepted definition of obsessive neuroses is that of Lewis: "Whenever a patient complains of some mental experience which is accompanied by a feeling of subjective compulsion so that he does not willingly entertain it, but on the contrary does his utmost to get rid of it, that is an obsession." The three essential elements, then, are a feeling of subjective compulsion, the resistance to it, and retention of insight. Some differentiate the obsessive neuroses from the compulsive neuroses, the latter defined as a stereotyped, usually innocuous behavior which the patient feels compelled to carry out. The urge to carry out the act is pressing, even imperative, and if the patient resists this urge he becomes tense and anxious. These obsessive-compulsive symptoms may occur in many different mental illnesses, neurotic and psychotic, functional and organic, but in the obsessive-compulsive neurosis they form the kernel of the illness and are the presenting symptoms. The subjective feeling of compulsion, the *sine qua non* of the obsessive-

compulsive neurosis, may not be present in other disorders where obsessive-compulsive symptoms are nevertheless described. For instance, in the obsessive-compulsive personality, although the individual may subjectively feel the compulsion, he does not unwillingly entertain nor resist these ideas, in fact accepts them as part of his routine existence.

As described later, the unacceptable subjective aspects of obsessive-compulsive symptoms may become acceptable through a shift to the "delusion-like ideas" of the psychotic depression or to the delusion proper characteristically related to schizophrenia. Likewise, in organic brain syndromes and other neurologic defects, there may be both a denial of the basic illness itself, as well as the obsessional behavior patterns, which are egosyntonic to the individual.

Confusion in precisely applying the words "obsession" or "compulsion" occurs because any symptom, such as an intrusive, maladaptive thought, recurring affect, or repetitious habit, all characteristic of psychopathology in general, is sometimes labeled obsessive, merely because it is repetitious. For instance, a strongly developed habit, a tic, or stereotyped behavior, is erroneously labeled an obsession or compulsion. It must be remembered that all symptoms are intrusive and repetitive (the repetition compulsion of Freud). Even such firmly fixed habits as smoking, nail-biting, or thumb-sucking, have been labeled as obsessive, but if the word is to have meaning,

some discrimination in its application must be made. There is no consensus among psychiatrists as to this precision, but from a review of standard usage it would seem that the following discrimination might be helpful: (1) Obsessive-compulsive neuroses should be limited to those situations where the individual has a feeling of subjective compulsion, does not willingly accept the idea or behavior, and in fact does his utmost to get rid of it. The individual feels forced to complete an act, even though he does not like to do it, and recognizes that it is meaningless, despite his compulsion. This should be distinguished from the perverse act where the individual feels forced to enjoy some behavior against his will. Thus, in the compulsive act the individual appears to perform the act in order to avoid anxiety, while in the perverse act he completes the act in the hope of obtaining pleasure. (2) If the individual does not resist the obsessive act or thought, that is, if his behavior is egosyntonic, the behavior can be an obsessive symptom or an obsessive trait only if it is otherwise similar in form to the behavior of the obsessive neurotic; that is, the repetitions occur frequently, usually many times a day; the acts or thoughts are complete; and they are usually mundane, routine activities which are bizarre because of their repetitiousness and inconsistency.

Obsessional symptoms should be distinguished from phobias, which are pure inhibitions of behavior; that is, the phobic minimizes anxiety by avoiding a real or symbolically frightening situation; the obsessive minimizes anxiety

by the ritualistic magical act. Many individuals demonstrate both phobic and obsessive behavior, but others show clearly one or the other.

Some motor behavior is pathological not only because it is repetitious, but because it represents incomplete acts, for example, tics or mannerisms. Often, these are erroneously labeled obsessive or compulsive acts, but it would be better to follow the traditional differentiation, namely, that a partial act is a symbolic act if it is a partial or incomplete motor pattern associatively connected with some past experience of a *non-conflictual* nature, and it is a symptomatic act if it is a partial act associatively connected with past *conflictual* experiences. In both instances, the action represents only a fragment of an intention, and for this reason lacks adaptive value. But it is best not to label these partial acts as compulsions, just because of their repetitive nature.

Another aspect of compulsive behavior is a symbolic doing and undoing, wherein the underlying impulse that is avoided by this behavior is never carried to fruition. Thus, the obsessive-compulsive is seldom the "killer," although he often fears that he will be the "killer." The obsessive-compulsive act, then, should be differentiated from the irresistible impulse where the unacceptable impulse has been carried through to completion, even though there may have been a long period of defensive resistance to this action, utilizing obsessive-compulsive symptoms. Likewise, habits that are repetitive

behaviors often accepted by the individual with little or no awareness of their repetitious nature, should not be designated as compulsions.

To reiterate, in considering the diagnosis of obsessional neurosis and its relationship to other disorders with obsessional symptoms, it is important to evaluate the patient's resistance to the obsessional ideas and rituals. As long as there is a recognition of the nonsensical quality of the symptoms and an attempt to resist the symptoms, it is a true obsessional neurosis. When the rituals become egosyntonic, a number of factors must be considered. There may be the denial of the symptom of the obsessional rituals without delusional elaboration, such as occurs in patients with underlying neurologic or central nervous system disorder, or in the individual with an obsessive personality. There may be a change from obsessions to delusion-like ideas, described by Jaspers as typically associated with affective disorders; these should be distinguished from the change in obsessions to the delusions characteristically related to schizophrenia.

Obsessive Personality

The individual described as an "obsessive character" demonstrates behavioral patterns typical of the obsessive neurotic, but does not see his behavior as symptomatic. When others accept such behavior, it may have adaptive value, and when others reject it, it will be maladaptive in terms of

the individual's interpersonal relations. These character traits are labeled in the psychoanalytic literature as "anal-erotic traits," denoting the point in the libidinal development of an individual where such behavior is predominant.

For instance, the boss of an obsessive character may describe his underling as a person who loves order, is thorough, accurate, fastidious, and organized. He may note that his employee has definite opinions, stands up for his rights, is self-confident, intelligent, and critical, has a keen sense of reality, is objective and unemotional. He will say that this person has unswerving integrity, abides by the rules, has a strong sense of duty, and is cautious. Furthermore, he will describe his employee as conservative, formal, and reserved, adding that he is thrifty and takes pleasure in his possessions, as well as shows perseverance, endurance, and a tremendous capacity for work. As can be seen, this is an ideal person for middle management, or the kind of person you would like to work on your car or television set, or perhaps perform surgery on you. This is an individual you would look for when hiring an accountant or quality control engineer.

At home, however, his wife describes this same person as pedantic, wasting time in meaningless indexing and note-taking. She may complain that her husband is defiant and stubborn, seeing only one way to do things, adding that he is a miser, hoards things unnecessarily, and treats people like possessions. Furthermore, she says he is self-centered, scornful of others, and

convinced he can do things better than anybody else. She complains bitterly that he lacks warmth, charm, and grace, noting that he is a hair-splitter, indecisive, inflexible, unimaginative, and lacking in the normal capacity for pleasurable relaxation.

Those of us who do family therapy are struck by the frequency with which hysterical women marry men with obsessive characters. Before marriage, they see in these men fatherly attitudes of strength, reliability, conscientiousness, and control, which will reinforce their own lack of control and compensate for their own emotional instability. It is only after marriage that they realize the price paid for this external control. Then, they become resentful and dissatisfied with their marriage, hoping to manipulate their spouse with hysterical outbursts, which unfortunately elicit only more stubborn, defiant behavior. With the disintegration of their interpersonal relationship, the individual with obsessive personality traits may experience anxiety and depression due to threatened desertion, but still may not see his obsessive character traits as symptomatic. In such instances, the diagnosis should not be obsessive-compulsive neurosis, but rather an anxiety or depressive neurosis in an individual with an obsessive-compulsive personality. As already mentioned, both obsessive neurotics and obsessive personalities may be associated with phobic anxiety, but rarely are patients with obsessive character traits or obsessive neuroses associated with the hysterical personality or the hysterical neurosis.

Obsessions and Depression

There are frequent reports concerning the relationship between obsessive personality traits and the appearance of depressive neuroses and psychoses, as well as the frequent occurrence of obsessive symptoms during both psychotic and neurotic depressions. Obsessions may appear episodically or cyclically, much as manic-depressive psychosis does, as well as during intervals between manic-depressive cycles. In fact, Tokes points out that many recurrent obsessional episodes probably mask an underlying psychotic depression, inasmuch as these individuals show other symptoms characteristic of this disorder, such as diurnal variations, poor appetite, weight loss, and early morning wakening.

This relationship between obsessions and depression has been investigated extensively by Gittleson in 359 patients with depressive psychosis. He points out that in the literature only 3.5 percent of schizophrenics are reported to have obsessive symptoms, while between 5.4 to 23 percent of psychotic depressions are associated in some way with obsessive symptoms or character traits. Gittleson found that 42 percent of his patients with depressive psychosis had obsessional personalities (although not necessarily obsessional symptoms) prior to the onset of their depressive episodes, and that 31.2 percent of the patients with depressive psychosis were obsessive during their depressive episodes. Of the individuals with a

premorbid history of obsessional symptoms, 75 percent continued with these symptoms during the depressive episodes, while 25 percent of the psychotic depressive patients developed obsessive symptoms for the first time during their depression. In the psychotic depressives, shifts from obsessional thoughts to delusional ideas occurred in 5.3 percent; when this occurred, the individual was more likely to make a suicidal attempt. In fact, Gittleson felt that obsessive-compulsive symptoms during depression seemed to have some protective effect against suicide. However, the content of the obsession during depressive episodes was often of a suicidal or homicidal nature. Gittleson noted the greater incidence of depersonalization among patients with psychotic depression with premorbid obsessive symptoms, which suggests that many American psychiatrists might consider this group not as psychotic depressives but as schizophrenics.

Obsessions and Schizophrenia

Both Straus and Rado (Part A) pointed out the frequency with which extreme obsessive symptoms are really a manifestation of an underlying schizophrenic process. Straus considered those obsessives preoccupied with contamination as probably representing a basic schizophrenic process wherein the individual has an underlying deficit in his pleasurable emotions. This is a concept similar to Rado's belief that anhedonia is common to both the obsessive-compulsive neurotic and the schizophrenic. Rado added that if

there were a further deficit in body image, due to proprioceptive deficits, schizophrenic behavior was likely. The contradictory nature of some of the genetic studies to be described may be due to the failure to distinguish between the schizophrenic with obsessive-compulsive symptoms and the true obsessive-compulsive neurotic. Identifying the schizophrenic obsessive-compulsive is extremely important because it considerably modifies prognosis and treatment. For instance, dramatic improvements have been noted in obsessives on phenothiazine regimens, probably reflecting obsessives with an underlying schizophrenic process. Here, the phenothiazines would modify the underlying schizophrenic process and hence the obsessive symptomatology, which was a defense against the underlying schizophrenic disorganization. It is important to realize that obsessive-compulsive symptomatology appears in the schizophrenic long before overt schizophrenic symptoms develop; seldom, if ever, does an overtly schizophrenic patient suddenly develop obsessive-compulsive symptoms. The obsessive-compulsive schizophrenic soon loses his insight into the meaninglessness of his obsessions. His behavior becomes increasingly disorganized and delusional, so that perhaps bills go unpaid, while his paychecks are hidden in drawers because of persecutory ideas; the house becomes a shambles, and despite compulsive washing, bed linen and clothes remain unchanged for months. With the final disorganization, one can see such extreme behavior as an individual who fears contamination standing

in a pan of Lysol, while smearing feces on the wall. By the time such behavior develops, there is usually no question of the underlying schizophrenia, as there are accompanying hallucinations, delusions, and disorganization in cognitive functioning.

Obsessions and Chronic Brain Syndrome

Obsessive-compulsive symptoms are also defenses utilized in the chronic organic brain syndrome as an attempt to deny illness or intellectual deficits. For instance, if such an individual is asked to perform beyond his diminishing capacity, his behavior becomes abnormally rigid, stereotyped, and compulsive. He prefers to remain in a familiar environment with a familiar life style, preoccupied with mundane activities. Such defensive obsessiveness is also seen in some impulsive patients who control their unacceptable impulses, although often unsuccessfully, by being rigid, conventional, cold, calculating, pedantic, and meticulous; and in some patients with underlying epileptic mechanisms, who likewise have difficulty in controlling their emotions and impulsive aggressiveness, except through obsessive mechanisms. In most instances, such patients show little resistance to their obsessive behavior. Thus, their behavior is not felt as being forced to do something against their will, but they accept their rituals as natural behavior which strengthens their weak control mechanisms. In these individuals, the obsessive behavior is egosyntonic, as in the obsessive

personality disorder, whereas in the obsessive neurotic the behavior is ego-alien.

Obsessions in Childhood

Frequently the first attack of obsessive symptoms occurs in childhood or adolescence. The behavior is in no way different from that of the adult obsessive-compulsive neurotic. However, Anna Freud and other psychoanalysts point out that children usually show symptoms that resemble those of the obsessional neurosis. These occur during the anal phase of development and are not strictly speaking neurotic, because they occur during the course of progressive development rather than as a consequence of regression. Such symptoms, during the first five years of life, occur more as a pleasant game than as a compelling activity to avoid anxiety. Anna Freud, in commenting on children who develop a true obsessional neurosis, suggests that such symptoms during childhood and adolescence (6-15 years of age) seem to be related to a precocious ego development with "distancing" of the ego functions from the drives; that is, there appears to be a premature intellectuality that leads to a particular perceptual and cognitive style. The regression in ego function which occurs in the childhood obsessive neurosis is not the type seen in childhood psychoses; that is, what the psychoanalysts call a "structural" ego regression. However, both the concepts of functional ego regression and premature intellectuality need considerable elaboration if

they are to have heuristic value in explaining the development of the obsessional neuroses.

The Genetics of Obsessive Behavior

One way to establish that a psychiatric syndrome is best understood within the disease model is to identify a genetic predisposition for the syndrome. This now seems relatively well established for schizophrenia, manic-depressive psychosis, epilepsy, and some of the episodic behavioral disorders associated with epilepsy. It is a frequent clinical observation that one of the parents, usually the mother of the obsessive-compulsive neurotic, has had obsessive-compulsive personality traits, but it is not surprising that a mother preoccupied with cleanliness should exaggerate what Rado calls the "battle of the chamber pot." One way to resolve the nature-nurture complexities of the family relationship is to express the heritability of the syndrome in terms of the monozygotic-dizygotic twin concordance ratios. For instance, in schizophrenia, this ratio ranges from 6.1 to 3.1 and relatively high ratios have been established for personality disorders (3.6) and psychophysiologic disorders (3.5). The importance of genetic factors in psychoneurotic disease is low, with a monozygotic-dizygotic ratio of only 1.3, similar to the ratios found in bacterial pneumonia (1.7) and fractures (1.5). Of all the psychoneurotic disorders, it is more frequently reported that obsessive behavior has a significant genetic determinant. Other studies seem to

contradict these findings, which may be due to their failure to strictly differentiate the obsessive-compulsive neurosis from the obsessive symptoms in schizophrenia or depressive reactions, both diseases with important genetic factors.

In a family study of 144 cases of strictly defined obsessional neurotics, Rosenberg evaluated 574 first-degree relatives and found only two instances of obsessional neuroses among the relatives, even though there was a prevalence of varied psychiatric illness among the first-degree relatives of 9.3 percent. Consequently, Rosenberg felt that this study did not support the view that the obsessional personality or classic obsessional neurosis had significant genetic determinants. Sakai investigated family pedigrees of a number of pathological conditions and came to the conclusion that in uncomplicated obsessions, that is, clear-cut obsessional neuroses, there was no hereditary predisposition, but in the complicated group where it was not clear whether it was a pure obsessional neurosis, there was often a family history of either epilepsy, manic-depressive psychosis, or schizophrenia. This probably reflects the fact that the obsessive symptoms were a pathological variation of the basic disorder.

In two in-depth studies of two pairs of monozygotic twins concordant for obsessive neurosis, the twins were concordant not only for the type of symptoms but also for severity of symptoms and course of illness. All had

early onset, fluctuating course, as well as exacerbation and remission of symptoms. They recognized that the obsessions were silly, but demonstrated endless ruminations, checking and rechecking, multiple phobias, and minimal feelings of depersonalization and derealization, which would have suggested a basic schizophrenic process. Even the investigators, however, doubted that this was adequate evidence for a hereditary predisposition in obsessive illness, and if there was a genetic factor, it was complex "which did not admit to present analysis."

Course of Illness

It is frequently said that the obsessive-compulsive individual has a poor prognosis, particularly if therapy is initiated may years after the appearance of the first symptoms. However, the few long-term studies available suggest that this is not true if one carefully distinguishes between the obsessive neurotic and other disorders with obsessive symptoms. The over-all improvement rates for the true obsessional neurotic are 60 to 70 percent, a rate similar to that of other neuroses.

Pollit studied a group of classical obsessive neurotics after excluding patients with obsessional personality disorders, with other neurotic reactions such as anxiety states, as well as those patients with obsessional symptoms occurring in the course of depression or schizophrenia. Meeting these criteria

were 150 patients, representing fewer than 2 percent of those seen either as inpatients or outpatients. In two-thirds of these individuals the course was episodic, with most attacks lasting for less than one year. Symptoms were more likely to appear between the ages of six and twenty-five years of age (68 percent), with only 4 of the 150 developing symptoms for the first time after age forty-five. Thus, there appeared to be decreasing risk with increasing age. The symptoms were often precipitated by environmental events, particularly sexual traumata.

Grimshaw, in a study of 100 cases seen six to fourteen years after the original diagnoses, found that 64 percent of this group improved both in terms of symptom disappearance and social functioning. Of the group, 40 percent were considered recovered or very considerably improved, and 77 percent maintained their pre-illness adjustment in that they were working at their normal level. Of the patients who recovered socially, 13 percent remained symptomatically unchanged or even worse.

Treatment

There have been enthusiastic reports on the treatment of obsessive-compulsive symptoms utilizing psychoanalysis, briefer forms of insight therapy, supportive therapy, electroconvulsive therapy, both major and minor tranquilizers, and even lobotomy. However, in Grimshaw's study,

where 31 patients received electro-shock treatment, 14 insight psychotherapy, 36 supportive psychotherapy often reinforced with medication, 3 lobotomy, and 16 no treatment, there appeared to be no significant difference in the recovery rates among these groups, nor were their recovery rates significantly different from those found in the literature supporting one or another specific therapy. In those patients who spontaneously improved without treatment, the author usually noted some significant environmental change. In view of the episodic nature of the neurotic obsessive, as well as the high spontaneous recovery rate, it would appear that drastic therapies are not indicated unless these rest on the diagnosis of an underlying mental illness with superimposed obsessive symptoms. Antidepressant drugs or ECT might be considered if the obsessive symptoms are significantly associated with depressive reactions; the major tranquilizers or even lobotomy indicated if the underlying process is schizophrenic. For the obsessive neurotic in his first episode, it would seem that supportive psychotherapy would be the treatment of choice, with more intensive psychotherapy if the symptoms failed to respond within one year.

It is the impression of older psychiatrists that obsessive-compulsive neurosis, as well as other structured neuroses, such as conversion and phobias, are now seen considerably less often than in the first half of this century, although there are no rigorous data to support this observation. If our psychodynamic concepts are correct, this should be the case, as the

residuals of Victorian child-rearing practices have been replaced by more permissive methods. Perhaps the price one pays for less neurosis is more delinquency and drug dependency. The ideal preventive child-rearing practice would be avoiding extreme permissiveness on the one hand, and authoritative attempts to enforce behavioral controls before the child's neuromuscular and intellectual development is capable of responding to these attempts on the other. We now have considerable data establishing maturational levels, so that we can delay toilet training until the lower bowel is capable of responding to enforced discipline from parents, and such discipline can be initiated after the height of the normal negativistic phase in the child's development. Whether there is a genotypical excessive fear-rage pattern associated with a deficit in pleasure responses that make an individual highly susceptible to the development of obsessive behavior, regardless of an enlightened child-rearing practice, is not clear, but this has been proposed by both Straus and Rado (Part A). If so, perhaps the best solution would be specific psychopharmacologic agents which would reduce fear-rage affects or increase pleasurable ones, thus reducing the risk of subsequent obsessive symptoms. In fact, Straus makes the interesting suggestion that a substance such as marijuana might increase what he calls the "sympathetic" emotions of warmth, growth, peace, and love. Now, that the active tetrahydrocannabinols have been identified and pharmacologic activity correlated with specific molecular structure, this hypothesis could be

systematically investigated.

It is reported that between 60 to 80 percent of obsessives respond well to psychoanalysis or insight psychotherapy. This would not be impressive in view of the reported spontaneous improvement rates, except that where detailed clinical data are given, one has the impression that the psychoanalytic patients were much more severe obsessive neurotics than those in the general sample of patients attending outpatient clinics. However, even the psychoanalyst recognizes that the obsessive patient presents unusual resistances to classical psychoanalytic techniques, due to several factors: First, the routine of therapy itself becomes just another ritual for the obsessive; second, the emphasis on insight in the psychoanalytic setting can be distorted by the obsessive's defenses of intellectualization and rationalization. To circumvent this, Rado suggests facilitating cathartic expression of rage and fear in "the memory content of the original cast and experiences that provoked them," and then once composure has been regained, show why the patient behaved as he did and how healthy people would have behaved in similar circumstances. Rado suggests that to help control the rage and fear once uncovered, one should teach the patient simple hypnoidal relaxation techniques. In this way, the patient first faces his fear and rage, learns from where they derive, and then conquers them through relaxation rather than through suppression. One technique I have found useful for facilitating this cathartic expression of fear and rage is a simple

variation in the treatment setting. The therapist's behavior, unlike that in the usual psychoanalytic setting, should not be consistent or neutral, but varied. One day the therapist can be verbally active, on another silent. Still another time, one rushes to the patient and shakes his hand in greeting, the next time one remains taciturn and aloof upon the patient's arrival. One can rearrange the furniture, utilize varied seating arrangements, or sometimes seat the patient vis-a-vis, other times put the patient on the couch. This is particularly useful when one is treating an obsessive-compulsive personality disorder; that is, when the obsessive's behavior is egosyntonic. Such techniques seem drastic by usual psychoanalytic standards, but are far less drastic than ECT or lobotomy now utilized in chronic, severe obsessive-compulsive neurotics who are not responding to psychotherapy.

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