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OBSESSIVE BEHAVIOR

So-called Obsessive-Compulsive Neurosis

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A. So-called Obsessive-Compulsive Neurosis

Sandor Rado

The first psychiatric observations on obsessive behavior date from the 1860's, but it was not until after the turn of the century that Freud opened the way to a deeper understanding of this disorder and its recognition as a well-defined clinical entity.[1] His classical description of the clinical picture, published in 1917, follows:

> The obsessional neurosis takes this form: the patient's mind is occupied with thoughts that do not really interest him, he feels impulses which seem alien to him, and he is impelled to perform actions which not only afford him no pleasure but from which he is powerless to desist. The thoughts (obsessions) may be meaningless in themselves or only of no interest to the patient; they are often absolutely silly; in every case they are the starting-point of a strained concentration of thought which exhausts the patient and to which he yields most unwillingly. Against his will he has to worry and speculate as if it were a matter of life or death to him. The impulses which he perceives within him may seem to be of an equally childish and meaningless character; mostly, however, they consist of something terrifying, such as temptations to commit serious crimes, so that the patient not only repudiates them as alien, but flees from them in horror, and guards himself by prohibitions, precautions, and restrictions against the possibility of carrying them out. As a matter of fact he never literally, not even once, carries these impulses into effect; flight and precautions invariably win. What he does really commit are very harmless, certainly trivial acts—what are termed the obsessive actions—which are mostly repetitions and ceremonial elaborations of ordinary every-day performances, making these common necessary actions—going to bed,

> washing, dressing, going for walks, etc.—into highly laborious tasks of almost insuperable difficulty. The morbid ideas, impulses and actions are not by any means combined in the same proportions in individual types and cases of the obsessional neurosis; on the contrary, the rule is that one or another of these manifestations dominates the picture and gives the disease its name; but what is common to all forms of it is unmistakable enough.
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> . . . he [the patient] can displace and he can exchange; instead of one silly idea he can adopt another of a slightly milder character, instead of one ceremonial rite he can perform another. He can displace his sense of compulsion, but he cannot dispel it. This capacity for displacing all the symptoms, involving radical alteration of their original forms, is a main characteristic of the disease; it is, moreover, striking that in this condition the *"opposite-values"* (polarities) pervading mental life appear to be exceptionally sharply differentiated. In addition to compulsions of both positive and negative character, doubt appears in the intellectual sphere, gradually spreading until it gnaws even at what is usually held to be certain. All these things combine to bring about an ever-increasing indecisiveness, loss of energy, and curtailment of freedom; and that although the obsessional neurotic is originally always a person of a very energetic disposition, often highly opinionated, and as a rule intellectually gifted above the average. He has usually attained to an agreeable high standard of ethical development, is over-conscientious, and more than usually correct.

Clinical Picture

The designation "obsessive behavior" will be applied to patients who have obsessive attacks and obsessive traits. For convenience, I shall subdivide obsessive attacks into spells of doubting and brooding, bouts of ritual making, and fits of horrific temptation. In time, the form of attacks may shift from one to the other. They may be mild or severe, last half an hour, an hour, or longer;

may be quiescent for a while or occur many times a day. Obsessive traits, however, once evolved, do not change significantly. I shall describe and illustrate first the three forms of attacks, and then the traits.

Spells of doubting and brooding may be described as a swinging back and forth between the same set of pros and the same set of cons without being able to reach a decision. They are thought activities that tend to defeat the purpose of thinking. Doubt may invade a belief, proposition, observation, or recollection, spreading from one to the other. The patient can trust neither his memory nor the testimony of his own eyes. Upon leaving home, he may feel forced to rush back to make sure that he turned off the light or locked a certain door, eventually repeating this "making sure" trip several times; or, upon sealing an envelope, he may have to open it over and over again to reassure himself that he has signed the enclosed check, etc.

In his bouts of ritual-making, the patient repetitively executes a sequence of motor acts. Most often these sequences are ceremonial and distortive elaborations of some routine of daily life, such as going to bed, getting up, taking a bath, dressing and undressing, settling down to work or finishing work. They may, however, also be composed of out of place or apparently nonsensical motor acts. Repetition of the sequence tends to be continued until the patient is exhausted.

The term “ritual-making” includes obsessive hand-washing, washing or cleansing of pieces of wearing apparel or other objects of daily use, as if they had been soiled or somehow contaminated; the obsession to count (for example, the number of parked cars), to touch (for example, every lamppost on the street), or, on the contrary, to avoid touching certain objects (for example, doorknobs), or to step on or avoid stepping on certain spots (for example, the pavement cracks) and the like; ceremonial and stereotyped elaborations of sexual performance, in particular, of its “before” and “after” phases; of the patient’s table manners and eating habits; of his toilet habits; of the way he makes and keeps social engagements, parts with money, makes purchases or presents gifts, etc.

In his “fits of horrific temptation” the patient, suddenly beset by the urge or idea to kill someone (characteristically a close and beloved relative), shrinks back in horror from a temptation so alien to his entire being.

Turning to the obsessive traits, we observe that the patient is over-conscientious in his own particular way. What he is mostly concerned about are the minutiae, the inconsequential details, the meticulous observance of minor rules and petty formalities. Specializing as he does in trifles, he is always in danger of missing the essentials. Similarly, his orderliness tends to be excessive and inappropriate, costing valuable time and effort; in his life, the clock is a menace. He may, for instance, keep papers on file that should be

discarded, and save or record matters of little or no importance. Upon arriving at his office, he may spend hours putting his desk in "order," arranging utensils and papers; turning at last to his job, he is capable of making important decisions hurriedly, without qualms. A scientist, though never noticing that his shoelaces were untied, was so meticulous in his literary documentation that his colleagues dubbed him a footnote fetishist. A patient recorded all his railroad travels from grammar school to high school, listing all the station stops, even when repeating the same trip. Another had his secretary keep a pyramid of indexes to his private files—a regular index, an ever-growing series of cross indexes, and an index of the indexes. Regardless of how rushed he may have been, whenever he consulted the files himself, he had to take time out to see whether the item concerned was indexed to perfection. Another, the product of a Victorian upbringing, from adolescence on kept a meticulous record in secret signs about his orgasms and failures—long before Kinsey and without the latter's point of view. Another, so instructed by his equally obsessive mother who always worried that he might catch cold, kept his supply of socks in the drawer in carefully separated piles marked "heavy," "light heavy," "heavy light," and "light."

A rough sketch of the obsessive patient would depict him as highly opinionated and proud of his superior intelligence, avowed rationality, keen sense of reality, and "unswerving integrity." He may indeed be an honest man, but he may also turn out to be a sanctimonious hypocrite. He is the ultimate

perfectionist. While very sensitive to his own hurt, he may, at the same time, be destructively critical, spiteful, vindictive, and given to bitter irony and to bearing grudges in trivial matters. Or, on the contrary, he may be overcautious, bent on avoiding any possibility of conflict. His "common sense" militates against what he views as fancies of the imagination: he is a "man of facts," not of fancies. He smiles condescendingly at people who are fascinated by mysticism, including "the unconscious" and dreams, but let him undergo some psychoanalytic treatment of the classical type, and he will switch to attributing oracular significance to slips of the tongue or the pen. As a "man of reason" he cannot admit even to himself that he is superstitious. His interest in fine arts is slight or pretended; his true admiration is reserved for mathematics, the exact sciences, technology, the new world of electronic computing machines. In contrast to the expressional (so-called hysterical) type, he rarely has artistic gifts and conspicuously lacks genuine charm and grace. His amatory interests are laden with ulterior motivations and pretense. His envy of a successful rival—in work, for example—may carry him to dangerous lengths: if the opportunity arises, he may subtly cut the man's throat—a token of his admiration and respect. This sort of thing is usually termed "ambivalence"—a term itself in need of clarification. Finally, the obsessive patient is almost never completely free from tension and irritability, though in general the degree of these characteristics fluctuates from slight to severe.[2]

Pathology

The Dynamics of Obsessive Behavior

We are now prepared to turn to the pathology of obsessive behavior. Over-reactive disorders arise from the organism's inability to handle danger situations effectively by its available means of emergency control: In this event, instead of acting as signals, its emergency emotions themselves inflict, or threaten to inflict, damage upon the organism. Thus, in the face of an external danger, far from increasing the organism's efficiency, they come to disorder its systemic operations, adding trouble within to the trouble without. We call this development "emergency dyscontrol." It begins in childhood with the parents' prohibitive measures, their punishments and threats of punishment. The disorder so created may continue or may flare up again in later life. It is then complicated by the consequences of the organism's own miscarried repair work which always includes unnecessary inhibitions and a reactivation of the long since outdated adaptive pattern of infantile dependence. Obsessive behavior is a subdivision of the class of over-reactive disorders.

In Freud's view, all neuroses originate in childhood, from conflicts between the child and his parents. Dependent upon loving parental care, the child is, at the same time, subject to parental discipline. Though the conflict and its consequences become repressed, they may nonetheless disturb the

patient's development and produce his neurosis. These findings, now widely recognized, are embodied in adaptational psychodynamics. As regards the specific etiology of obsessive neurosis, Freud held that the patient's development was to some extent arrested and thrown back to an earlier stage. The patient's "genital level" was weakened by "fixation" at the previous level; his regression to that level, at which the child's life was dominated by "anal-erotic and sadomasochistic impulses," was considered the key to his obsessive neurosis.

Freud's theory calls attention to the processes of bowel training. The child must be helped to bring evacuation under voluntary control. However, bowel control presupposes maturation of the requisite neuromuscular apparatus. If the mother is overambitious, demanding, and impatient, and if the child is marked by a particular combination of characteristics, then the stage is set for the battle of the chamber pot.

Irritated by the mother's interference with his bowel clock, the child responds to her entreaties with enraged defiance, to her punishments and threats of punishment with fearful obedience. The battle is a seesaw, and the mother, to fortify her position, makes the disobedient child feel guilty, undergo deserved punishment, and ask forgiveness. This indoctrination transforms the child's fear into guilty fear, and impresses upon him the reparative procedure of expiatory behavior. The mother-child conflict

provokes in the child a struggle between his own guilty fear and his own defiant rage. It is a characteristic of the type of child under consideration that his guilty fear is always somewhat stronger; sooner or later, it represses his defiant rage. Henceforth, his relationship to the mother, and soon to the father, will be determined by this motivating system: *guilty fear over defiant rage* or, *obedience versus defiance.* The severity of the conflict, sustained by the inordinate and unrelenting strength of fear and rage, perpetuates this outcome. In our view, with the establishment of this motivating system, the child acquires a crucial factor toward a predisposition to obsessive behavior.

Freud's theory of obsessional neurosis features a "sadistic super-ego" and a "masochistic ego," a dramatization unquestionably inspired by observations similar to the ones from which our interpretation derived. Thus, our interpretation is a development of Freud's early insight. On the other hand, his emphasis on the destinies of evacuative pleasure, their significance in the causation of obsessive behavior, is refuted by clinical experience. He assumed that bowel obedience forces the child to relinquish evacuative pleasure by "sublimating" the desire for it or by stemming its tide by "reaction-formations." These developments were then reflected in the shaping of obsessive symptoms. Bowel defiance, he thought, increases the child's evacuative pleasure. The fact is, however, that children forced into bowel obedience enjoy the evacuative act just as heartily as other children, whereas bowel defiance is often enough strengthened by the intent to avoid

an act rendered painful by an anal fissure or some other local disturbance. With her insistence on bowel regularity, the mother hurts not the child's evacuative pleasure but his pride in having his own way. Furthermore, one sees obsessive patients whose bowel training has been uneventful, but they are nonetheless marked by the same severe conflict between guilty fear and defiant rage; it originated in other behavior areas. The future obsessive patient's emphatic obedience and stubborn defiance, far from being limited to his bowel responses as a child, are spread over his entire behavior.[3]

The pathological development of conscience is directly traceable to the unusual strength of two presumably inherited traits, hopelessly at variance with each other. One is the child's craving for autonomous self-realization, a derivative of his primordial belief in his own omnipotence that drives him to reshape the world about him in his own image, which may also be described as a strong bent for alloplastic adaptation. The other trait is his rationalism, his realistic foresight that forces him to take no chances when it comes to preserving the parent's loving care. In adult life, this trait is manifested as a strong desire to be treated by one's social environment as an admiring parent treats a favorite child. Since, however, the parents insist on obedience, and later, society on adherence to its laws and mores, the organism so constituted will eventually do its utmost to conform.

That a child is born to stubborn and tenacious self-assertion may be

surmised from the inordinate strength of his rage. This provokes the parents into severe retaliatory measures which, in turn, elicit his defiant rage and even stronger fears. He is thus forced to move with undue haste from ordinary fear of punishment contingent upon detection to fear of conscience, that is, fear of inescapable punishment, and then to guilty fear and the reparative pattern of expiatory self-punishment. Automatization at such an early stage makes these mechanisms over-strong as well as rigid. Healthy conscience fulfills its adaptive function smoothly; it has little need for guilty fear and the reparative work of repentance. But with early automatization, conscience grows into an organization dominated not by the healthy mechanisms of self-reward but by the morbid mechanisms of expiatory self-punishment. The latter are morbid because they are automatized operations not of, but in, the patient; he does not initiate them, nor is he or his environment aware of their meaning; he is aware of only the damaging effects these non-reporting processes inflict upon him. A conscience so constituted will diminish rather than increase the organism's capacity for happiness. It is an example not of autoplastic adaptation but of autoplastic maladaptation.

A closer look at these developments is indicated. Endangered by its rage, and forced to control it, the organism does not rely on merely repressing it; through accumulation, repressed rage may, indeed, reach the point of explosive discharge. To forestall this possibility, as its next precautionary move, the organism turns the larger part of its repressed rage against itself,

or, more precisely, against the rest of its repressed rage—the strategy of defeating the enemy with the help of its deserters. The retroflexion is achieved by assimilating repressed rage with the now-prevailing mood of repentance. This explains the clinical fact that the child's (and later the adult's) self-reproaches may far exceed in vehemence the reproaches his parents ever leveled against him, and that his self-punishments may be far more severe than were his parents' threats. The strength of these mechanisms of self-control is determined not by the actual attitude taken by the parents but by the strength of the child's own retroflexed rage.

Fear of conscience and its derivative, guilty fear, rest on the belief in inescapable punishment. This belief cannot stem from experience. The child knows he was punished only when caught. Nor can religious indoctrination be its ultimate source, for it flourishes in agnostic patients as well.

The chain of psychodynamic inferences leads us back to the infant. Elated by the success of his early muscular activities, the infant pictures himself as an omnipotent being. The hard facts force this grand illusion to recede slowly into the range of non-reporting processes. Sensing that his beloved omnipotence is about to evaporate, the child fancies that he has merely delegated it to his parents: they exercise *his* magic powers *for* him. He is then terrified to discover that the parents can turn *his* omnipotence *against* him; he has no way of telling what they can now do to him. The dread of

inescapable punishment, appearing within his fear of conscience and within his guilty fear, is basically a dread of his own omnipotence, which he now feels the parents can cause to work in reverse. It is powerful enough to retroflex the bulk of his repressed rage. We must assume that stronger-than-average residues of primordial omnipotence are a factor in the predisposition to obsessive behavior.

In the healthy individual, the supreme pleasure of genital orgasm gives rise to a host of affectionate desires, which soften rage by their counterbalancing effect. In the obsessive patient, in whom the pleasure of genital orgasm is seen to be comparatively weak, these derivative motivations are enfeebled, without power to soften rage; the job must be done, and is being done, by conscience alone.

One must assume that a shortage of sexual love is genetically determined; in any case, we consider this deficiency a factor in the predisposition to obsessive behavior. It may well be that, genetically, it is linked with the innate strength of rage.

The early rigidity of conscience vitiates its adjustment to the conditions of adult existence. One must qualify the oft-repeated statement that the obsessive patient is over-conscientious: he is that chiefly, if not only, in the areas of infantile discipline. His silly excesses in cleanliness, orderliness,

regularity, and punctuality show that his conscience still operates in the world of the nursery—ruled most often by an obsessive mother.

Some twenty-five years ago, listening to the jeremiad of a tortuous and self-tortured patient, the idea struck me that his obsessive attacks derived from the rage attacks of his childhood. This discovery, abundantly corroborated by subsequent experience, sparked the entire investigation here presented.

In a temper tantrum the discharge of rage is explosive. In an obsessive attack we see the organism struggling with the imperative task of ridding itself of its morbid tensions. Here the discharge of rage, continuously interrupted by counter-discharges of guilty fear, is extremely slow and always incomplete.

The dynamic structure of such attacks is best seen in a simple bout of obsessive ritual-making. Here, driven by his tension, the patient performs a sequence of two motor acts and then goes on repeating this same sequence over again. For example, going to bed, he places his shoes on the floor first at right angle, then side by side; then again at right angle, then side by side again, etc. Analysis shows that both acts are symbolic. One expresses the intent of defiant rage to carry out a prohibited desire; the other, the opposite intent of guilty fear. Consequently, one act achieves a fragmentary discharge

of morbid rage tension; the other, of morbid fear tension. Repetition of the sequence is continued until tension is somewhat reduced and the patient is exhausted. In its entirety, the process is a mechanism for the alternating discharge of opposite tensions. We call it an interference pattern of discharge; its mode of organization explains why it is so slow and tortuous. If the patient tries to stop, his tension becomes so unbearable that he must yield to it and continue. In other forms of obsessive ritual-making, the two opposite tensions are discharged by repeating a single act or a stereotyped series of acts; though the motor picture is different, the pattern of discharge is built on the same principle.

The interference pattern of discharge also operates in the brooding spell. Here the discharge is mediated not by seesawing motor acts but by trains of thought traveling in opposite directions. However, doubt and brooding may eventually open the door to mechanisms which are familiar to us from the nonschizophrenic form of paranoid behavior. While, as a rule, their appearance in this context is transient and their form rather rudimentary, such a development is an unwelcome complication of the obsessive picture. In these mechanisms the patient discharges not naked tensions but, in prolonged separate phases, the full-blooded emergency emotions of guilty fear and guilty rage. Through the quasi-delusions of the hypochondriac mechanism, he releases excessive guilty fear at the organismic level; through the quasi-delusional self-preoccupations of the referential

mechanism, he likewise releases excessive guilty fear, but this time at the social level; on the other hand, through the quasi-delusions of the persecutory mechanism, he vents, in presumed self-defense, his guilty rage.

The problem of discharge in fits of horrific temptation will be considered later.

At this point the relation of full-blooded emotions to their denuded tensions must be clarified by completing our examination of the organism's repressive activities. The patient is just as unaware of his guilty fear as he is of his defiant rage. As stated before, excessive guilty fear prompts the organism to repress its slightly less excessive defiant rage. We must now add: Humiliated by its guilty fear, the organism soon represses its guilty fear as well. The outcome is a tripartite motivating system: restored pride over repressed guilty fear over more strongly repressed defiant rage. In contradistinction to the brute pride that the organism takes in its self-assertive rage, we call this restored pride domesticated or moral pride; now proud of its virtuous conduct, the organism does not choose to remember that it has been forced into morality by its guilty fear of inescapable punishment.

These repressions do not, however, sufficiently control the patient's excessive, if not altogether inappropriate, emergency emotions. Though the repressive mechanism succeeds in inhibiting their characteristic feeling tone

and peripheral expression, as well as the thoughts engendered by them, nevertheless, the overflowing tensions of the patient's fears and rages penetrate his consciousness. Though his tension fluctuates in degree, he feels tense most of the time, complains about it, and recognizes it when it is brought to his attention. Excessive emergency emotions tax the power of the repressive mechanism. Healthy persons, too, experience naked tensions arising from an imperfectly repressed emotional turmoil, though far less frequently, but in the obsessive patient this failure is chronic and produces far more serious consequences.

Our next task is to trace the multifarious influences that contribute to the shaping of obsessive attacks and traits. The rage that filters through in an obsessive attack is the characteristic reaction to frustration. Some of the patient's present resentments repeat the ones he had experienced in childhood when his parents denied him fulfillment of his most highly valued desires. His rage was then, as it is now, his instrument for making them give in or go away. He wished they were dead. Of course, he took it for granted that when needed they would promptly return—and behave. The child's quick death wishes, reflecting his ignorance, are not really murderous; they are only coercive, as are so many other expressions of his rage.

At first the child uses rage to force satisfaction of a particular prohibited desire. Later, as a matter of policy, he wishes to keep the parents under

permanent control; they should let him have his own way and still love him. While continuing to serve other ends, the desire to dominate becomes a goal in itself. Next, the child wishes to eliminate, or at least dominate, his siblings; they must not be allowed to compete with him for the position of the favorite child. This motive produces the clinical pictures of "sibling rivalry." The obsessive patient is the child who has, despite innumerable defeats, retained these attitudes for life. His ritual-making and brooding perpetuate the struggle for dominance, drawing their original dramatic contents from the long-since-repressed conflict situations of his early years. This remarkable fact shows that its repressed rage glues the organism to humiliating experiences of its past. Its thirst for wiping out those humiliations takes precedence over its desire to repeat routine gratifications: Triumph is a stronger self-reward than routine pride.

The child's first orgastic experience, made often by chance, awakens his desire for genital self-stimulation. This applies to boys and girls alike. The mother (father) counters the child's practice with a campaign of deterrence, threatening, among other things, punitive removal of his (her) guilty hands and of the boy's penis (Freud's "threat of castration"). He (she) is now caught in the clash between two groups of forces of almost equal strength: *prohibited sexual desire plus defiant rage* versus *fear of conscience plus guilty fear.* This is a precarious situation; to touch or not to touch is now the question. He (she) may find a mode of orgastic arousal that does not depend for its success upon

touching the genital organ. He outsmarts the parents by sticking to their words. Later, he will try to circumvent, in the same manner, prohibitions of whatever kind.

If however, guilty fear prevails and he represses his prohibited genital desire, he may switch his pleasure-seeking tendency and self-stimulatory practices to his anus, or resign and develop a tic, or go into ritual-making. It is almost unbelievable to what extent the obsessive ritual may draw its basic conflicts from the now-repressed tragedies of the past. This is particularly true of the struggle, begun in childhood and resumed at puberty, to achieve the genital abstinence demanded of him.

The child may advance his forced precautionary moves to an earlier target point. His parents' intimacies, which he witnessed by chance if not surreptitiously, aroused him. Were it not for his parents' example, he would not have to struggle with his temptation. His effort to keep the parents sexually apart may continue under the guise of an obsessive ritual.

In passing, it should be noted that motives of this kind may produce socially valuable results rather than disorder. A brilliant electrical engineer, in his middle twenties, had more than a dozen patents to his credit. His inventions ranged over a wide variety of technologically unrelated problems. Until his treatment, he never realized that, each time, his success hinged upon

preventing the formation of an electric spark. He was an only child who, as an adolescent, had managed to break up his parents' marriage; his infantile obsession to prevent them from having another child eventually besieged his scientific imagination.

The organs the obsessive patient most often uses in his ritual-making are the four extremities. Their psychodynamic significance dates from the corresponding stages of neuromuscular maturation and derives from the sequence of illusions which the child develops about his newly won powers. Gorged with his success in co-ordination, he grandiosely overestimates the might of his hands and feet, in particular, of his trampling feet. This illusion persists in the patient's ritual-making, whose procedures, as we shall see, are performed not for their physical but for their hoped-for magical effect.

Earlier, the child believes that his mouth, in particular the biting teeth, is his most powerful weapon. He will have fear-ridden dreams —as will later the adult—in which he loses his teeth; this means that he loses the magic power of his coercive rage to secure domination for him and the magic power of his sexual organ to give him orgastic satisfaction. Attempts to control the dangerous power of teeth may eventuate in their compulsive grinding in sleep. The charm may spread to saliva (compulsive spitting) and to speech. Verbal attack knows no limits when words have magic power. This is seen in the obsessive patient's resort to magic words and in the ordinary citizen's use

of cursing. As we shall later see, the magic of words is also a significant component in the dynamics of stammering.

To spit, void, or defecate upon someone are the expressions used in the vernacular to signify contempt. This language usage derives from the annihilating magical effect attributed by the child to his excretions and evacuative acts. But, in the contrary emotional context of yearning for help, the same excretions are relied upon to produce a healing effect. The puzzle of their antithetical meaning and significance is solved by the simple fact that they are utilized as tools by love and hate alike. In ritual-making, no non-reporting motive occurs more frequently than the fear of having been contaminated by someone's secretions or excretions, or the desire thus to contaminate someone else.

The fact that magic thought appears in the shaping of obsessive behavior was discovered at an early date by Freud and Ferenczi. We have shown that magic's deepest root is the infant's belief in his own omnipotence, in his primordial self which we view as the nucleus of the action self. From this source derive the obsessive patient's superstitions which he is reluctant to admit even to himself.

Our theory of primordial self also explains the fact that magic is universal. In our culture, its most common manifestations are our wishful or

fear-ridden dreams and daydreams, the creative arts, the performing arts, the born leader's charism, etc. In emotional thought—be it love-bound, rage-bound, or fear-bound—the power of the wish corrects reality. To a degree, all emotional thought is magic thought. In pathology, however, the purpose for which magic is used depends upon the nature of the disorder. The obsessive disorder specializes in coercive magic; the expressional (so-called hysteric), in the performance magic of illusory fulfillment. In the former, unknown to himself, the patient seeks to break his prohibitive parent, intent on turning him into a first-class slave; in the latter, likewise unknown to himself, he materializes his adolescent dreams of drama, romance, and glory.

We shall now revert to the patient's fits of horrific temptation. Though hardly more than a signal of rage below, his temptation shakes the patient's proud morality. His reaction of horror amounts to a voluminous discharge of guilty fear; it may take him hours to regain his composure. His groping for safeguards tends to disrupt the pattern of his routine activities; he is distracted, makes mistakes, loses himself in aimless repetitions, and does not really know where to turn.

It would be a serious mistake to surmise that the patient bursts with repressed rage. On the contrary, closer examination shows that his outward-bound rage has been almost completely retroflexed, turned upon himself; all he can do with it now is to torture himself. To be able to vent it, instead, upon

the environment would be his salvation. This inspiration of despair is, indeed, the secret message that his horrific temptation to kill conveys: “I wish I were a murderer.”

Extreme retroflexion of rage may be precipitated by opposite errors in education. Too harsh discipline is bound to break the child; over-solicitousness is likely to disarm him: “My parents are so nice to me, I cannot allow myself to get angry at them even when I should.” A patient who suffered from the horrific temptation to kill the grandchild she loved most had been overindulged all her life.

Horrific temptation may take the form of obsessive confession, a mechanism first described by Theodor Reik. Learning about a crime from the newspapers, the patient may at once be convinced that it was committed by himself. Non-reporting guilty fears may accumulate from an endless series of non-reporting temptations. To relieve such insupportable guilty fears, to secure deserved punishment and eventual forgiveness, the patient may confess to a crime he never committed. Fëdor Dostoevsky, our best pathologist of conscience so far, described memorable examples of this obsession. Police chronicles literally abound with such cases.

If the patient develops a severe depression, his morbid self-accusations not infrequently refer to a beloved person whose actual wrongdoings he

blames on himself. Such self-inculpatory fits have, invariably, an ironic intent.

Under the accidental influences of his changing life situation, the patient may shift his doubts and broodings from one favored subject matter to another, and move the seesaw of his symbolic transgressions and repentances further and further away from the original contents of his conflict. But the motivating system responsible for these activities remains the same, showing that the obsessive attack must be understood in terms not of its dramatics but of its function of discharge.

From the model of the patient's obsessive attacks, we can readily understand his obsessive traits, for, in one way or the other, most of these permanent marks derive from the same motivating system—perpetuation of the infantile conflict between the child's over-strong tendency to self-assertive domination versus his still stronger clinging to the security of being loved and cared for. The more environment-directed rage slips through, the stronger the self-assertive aspect of his traits; and, on the contrary, the keener his rational foresight and prudence, the more prevalent will be his traits of cautious avoidance.

The patient's craving for perfection is a direct expression of his primordial almightiness; to the warning that no one can be perfect in an imperfect world, he will respond with a polite smile.

Special mention must be made of the attitude the obsessive patient displays toward the competitive aspects of life. He may be prudent enough to limit his fierce competitive efforts to his major areas of aspiration. He often professes the doctrine of fair play which calls for competitive cooperation, victory through superior performance. At the same time, not always unwittingly, he may quietly employ all the tricks of sibling rivalry, seeking to discourage if not to disqualify his most dangerous competitors from staying in the race, then rush to offer assistance to his victims. When in a slightly elated state, he may be seen competing indiscriminately for almost anything.

In the obsessive patient, the manifold and widespread motivations ordinarily sustained by affection and sexual love are diminished in both strength and scope, presumably because his genital orgasm lacks the overwhelming force and pleasure it has in healthy people. We suspect strongly that this is an innate trait. It must not be confused with the patient's capacity for sexual performance, which may be unimpaired. Unwittingly, the patient is prone to make up for his romantic impoverishment by pedantic execution of the act. He is not exactly a lover, but he is a dependable ritual-maker. If an impairment of performance is present, however, its pathological mechanisms are the same as elsewhere. The question of sexual pain dependence will be dealt with in another context.

A few words should be added about the obsessive patient's

"ambivalence." Bleuler, who coined the term in his work on schizophrenia, distinguished between intellectual, emotional, and volitional ambivalence. We trace these manifestations uniformly to the severity of the underlying obedience-defiance conflict. Bleuler stressed the fact that the schizophrenic patient, like the child, tolerates the coexistence of conflicting thoughts or feelings or impulses in his consciousness. The opposite is true of the obsessive patient. While the schizophrenic patient is, or appears to be, unaware of such conflicts in him, the obsessive patient is, more often than not, only too keenly aware of them. He ponders unendingly: Must he give in, or could he gain the upper hand without giving offense? Facing the same question, the ordinary citizen makes a decision and sticks to it. But to the obsessive patient this question is a dilemma that throws him into endless broodings and keeps him engaged in countless postmortems. Since the two tendencies concerned are almost equally over-strong, he will always believe that he made the wrong decision. He could have won, why didn't he try? If he wins, he is afraid he will have to pay for it. He cannot make up his mind: Does he love his wife or does he hate her? If he loves her, why does he resent almost everything she does? And if he hates her, why does he cling to her so firmly? He is aware that his indecision is both widespread and chronic.

The obsessive patient excels in repeating the component acts of performance. Repetition enters as an organizing principle into his ritual-making, brooding, and, to some extent, the entire routine of his daily life. Its

origin is unmistakable. Repetition is pre-eminently the technique employed in the learning process. Whatever the child has to or wants to learn must be repeated and practiced. The point is that it is the parents who impose this maxim upon him. The defiantly obedient child, the future obsessive patient, carries it, in utmost seriousness, to absurdity: "All right, all right, if this is how you want me to do it, I shall go on and on until *you* get sick and tired of it." His senseless use of repetition is a travesty of the learning technique. Aside from this, repetition is forced upon him by the prompt interdictions of conscience. Interrupted by them as soon as he starts, he must make a fresh start over and over again. He never gets beyond the first step toward the non-reporting goal of his forced effort. Without loss of ironic intent, repetition thus becomes an integral feature of the interference pattern of discharge.

Stammering is a speech disorder closely related to obsessive behavior. They have two dynamic features in common—motivating system and interference pattern of discharge. The stammerer gives a drastic illustration of the afore-mentioned point: He, too, gets stuck at the start—in the first letter or syllable—and repeats it until he is able to complete the word. In stammering, the organism acts upon the early illusion that its most powerful weapon is the mouth; its rage is channeled into speech. Naturally, in the motivational context of rage, the magic of words is coercive or vindictive. To the non-reporting range, the letters or syllables in which the patient most often gets stuck signify the beginning of a verbal assault—obscenity, cursing,

etc. Without knowing why, he gets scared. Guilty fear promptly stops his speech, as if to warn, "Watch your words." This mechanism explains why stammering disappears in situations which obviate the necessity of precautions. As is generally known, the stammerer's speech is undisturbed when he is alone, or recites the same lines together with an entire group, or when he sings, etc. Otherwise, humiliated by his defect, he tends to withdraw and reduce his speech to a minimum; this phobic avoidance is, of course, a secondary development. Or, if the patient is angered by his defect, he will stubbornly insist on speaking and finishing what he wants to say. In this effort, one of my patients pressed his teeth together, blushed, his cheek muscle vibrating restlessly and going into spasm. I should like to close these remarks on stammering with a personal reminiscence. When I was a young psychoanalyst, a dear friend and mentor of mine referred a severe stammerer to me for treatment, explaining the nature of this disorder as follows: "Stammering is a conflict between the urethral-erotic tendency to expulsion and the anal-erotic tendency to retention, displaced upward to the mouth. *Eine Verschiebung von unten nach oben,* that's what it is." In this explanation, my friend's romantic enthusiasm for the libido theory eclipsed his native brilliance; he was, in human quality as well as in scientific achievement, the towering figure among Freud's early disciples.

Like all chronic disorders, obsessive behavior imposes unfavorable modifications upon the organism's pattern of interaction with its social

environment. It forces the patient to live on an ever-rising obsessive note of tension, lowering his adaptive efficiency, capacity for enjoyment, and active achievement in life.

The onset and further course of the disorder, as well as the measure of its severity, vary widely. In evaluating the degree, we have to consider three pathological factors: The first is the degree to which the self-punitive mechanisms of conscience have become automatized; the second is the degree of the patient's pleasure deficiency, which is indirectly responsible for his severity of conscience; the third, closely linked with the first, is the presence and degree of pain dependence.

Clinically, we can readily appraise degrees of automatization and residual flexibility, by watching, as we do in a laboratory experiment, the influence that stress, absence of stress, and other factors have upon an established response. But about the organization of these highly significant processes we are completely in the dark and will probably remain there until behavior physiology comes to our aid. Unfortunately, as far as mechanisms of conscience are concerned, little help can be expected from animal studies.

Pain dependence is a chronic disturbance imposed upon the organism chiefly by its own retroflexed rage, which, in turn, is an outcome of restrictive upbringing. Its various forms may be observed in the pathological context of

any disorder. In the obsessive patient, the form called moral pain dependence is most frequent. Its development may be summed up as follows: His omnipresent and unrelenting fear of conscience—fear of inescapable punishment—and his refusal to take chances with his security force the patient to shy further and further away from activities that could lead him into temptation. From its original area, the inhibition thus spreads to include the approaches to this area, thence to include approaches to these approaches, and so on in ever-widening circles of precautions.

A graphic and typical illustration of this process is supplied by a patient who, as an adolescent, was prohibited from visiting a house of ill repute. He avoided the house as ordered, then he felt compelled to avoid the street in which the house was located, and eventually he avoided the entire section of the city. By coincidence, he subsequently had to move to a town in which there was no house of ill repute; he departed with a sigh of relief. Unfortunately, in this town he discovered a former schoolmate who had since acquired an unsavory reputation; step by step, he developed the same series of precautions. Changing circumstances are powerless to terminate obsessive preoccupation; the same idea will force itself upon the patient in another form. In this patient, his house-of-ill-repute experience became the hidden content of an obsessive ritual.

Yet no man can stay alive without satisfying, one way or another, the

organism's minimal hedonic requirements, and so the patient is forced to find solace and high moral gratification in the fact that he is a "fine man." He discovers more and more opportunities to "fulfill his duty," imposing upon himself burdens and sacrifices which often enough do no good either to him or to anyone else. He becomes a self-styled martyr—without a cause. In moral pain dependence, under the supremacy of retroflexed rage, conscience defeats its purpose.

However, the obsessive patient may also suffer from sexual pain dependence. As a source of pleasure, genital orgasm is unrivaled. If, as they usually do, the parents interfere, the organism puts up a hard fight to protect it. We have already seen that the child may circumvent the parental prohibition by indirect modes of stimulation. But there are other methods. Defeated as a child by the campaign of deterrence, the adolescent may find himself incapacitated for standard sexual performance. By chance, he then discovers that his submission to humiliation or other abuse has a disinhibitory effect upon his performance. Analysis reveals the reason: He has taken the inescapable punishment beforehand; now he is entitled to prove that he deserved it. He develops the practice of inviting abuse (short of serious injury) from the mate, thereby restoring his (her) capacity for performance. We call this practice the fear-ridden or submissive version of sexual pain dependence.

Another patient may discover that coercive rage takes care of his trouble. Assuming the role of the authority, he (she) inflicts the dreaded punishment upon the mate, enjoying vicariously the mate's suffering. The triumph unfreezes and strengthens his (her) sexual potency even more. This practice is called the enraged or triumphant version of sexual pain dependence. The two versions of this disturbance are far less self-destructive than is moral pain dependence.

I shall now sum up the etiologically significant results of this analysis. Obsessive behavior is based on a predisposition which is acquired in childhood and includes five clearly discernible factors: (1) over-strong rage; (2) guilty fear made stronger by retroflexion of the larger part of repressed rage; (3) stronger-than-average residues of primordial omnipotence that make rage strong and its paradoxical retroflexion possible; (4) relative pleasure deficiency in the area of genital orgasm, with its consequent enfeeblement of genital love and affection—a deficiency that makes it imperative to control repressed rage by retroflexion; (5) intelligent foresight leading to realistic fears. Presumably, the acquired predisposition to obsessive behavior is based on a genetic predisposition in which the over-strength of rage may be linked with the pleasure deficiency of sexual orgasm.

Parental punishment initiates a pathological development of conscience —repression of defiant rage, first by fear of punishment contingent upon

detection, and, later, by fear of conscience—of inescapable punishment and guilty fear. The child's fear that the parents can make his omnipotence work in reverse increases his fear of conscience and guilty fear to such a degree that they become capable of retroflexing, as an added safety measure, the larger part of his repressed rage. Retroflexed rage makes remorseful self-reproaches and expiatory self-punishments all the more severe.

Accumulation of excessive emergency emotions in the non-reporting range—guilty fear and the rest of outward-bound rage—forces the organism to create an outlet. His denuded tensions filter through the pain barrier of repression and produce the obsessive attacks with their interference pattern of discharge. Horrific temptations arise when the retroflexion of rage is carried to an extreme. They show that, in his despair, the tortured patient would prefer to be a murderer.

Looking once again at the motivating system, we find rage at the bottom, in the key position: restored pride over repressed guilty fear over more strongly repressed defiant rage. Beyond a shadow of a doubt, in the etiology of obsessive behavior, the ultimate psychodynamically ascertainable factor is rage.

In 1926 Freud summed up his etiological theory of neurosis in the following beautifully phrased (in the German original) passage that ends on a

disarming note:

> These minor rectifications cannot in any way alter the main fact that a great many people remain infantile in their behavior in regard to danger and do not overcome age-old determinants of fear *[Angst],* To deny this would be to deny the existence of neurosis, for it is precisely such people whom we call neurotics. But how is this possible? Why are not all neuroses episodes in the development of the individual which come to a close when the next phase is reached? Whence comes the element of persistence in these reactions to danger? Why does the effect of *fear* [Angst] *alone* seem to enjoy the advantage over all other effects of evoking reactions which are distinguished from the rest in being abnormal and which, through their inexpedience, run counter to the movement of life? In other words, we have once more unexpectedly come upon the riddle which has so often confronted us: whence does neurosis come—what is its ultimate, its own peculiar meaning? After whole tens of years of psychoanalytic work we are as much in the dark about this problem as ever. [Italics supplied.]

In the above paragraph, Freud does not so much as mention rage, or even imply it, say, by some reference to his so-called "death instinct," that "instinct of destruction and self-destruction."

I have shown here that persistence and excessive strength of the child's fears are necessary consequences of the fact that the child— and later the adult—is forced to hold his rage in check. My examination of the other psychoneuroses (the over-reactive and mood-cyclic disorders of our classification) has led me to the same conclusion. Summing up a series of studies, I wrote in 1955:

> Caught in the clash between their own defiant rage (violence from within)

> and the retaliatory rage of their parents (violence from without), these patients [suffering from over-reactive and mood-cyclic disorders] have emerged from childhood with an established pattern of adaptation that forces them unawares to damage themselves in order to avoid the dreaded danger of damaging others. Their suffering is increased if they develop pain-dependence.

The primary task of education is to domesticate the infant, to make him fit for social life by taming his rage. If this process miscarries, the child's inadequately controlled rage will cause behavior disorders. Trapped for decades in a labyrinth of misconstructed theories, it may well be that we are at last finding our way back to the obvious.

From the analysis of obsessive behavior, we derive a general insight. Since, in all over-reactive and mood-cyclic disorders, the root disturbance is emergency dyscontrol, the principal dynamic function of these disorders is to discharge the insupportable tensions created by emergency dyscontrol. Or, to put it more precisely, these disorders are created by the biological necessity to discharge insupportable tensions; in each of them, formation of the characteristic clinical picture is then influenced by contributory causes.

The physiological pathology and the genetics of obsessive behavior have hardly reached even the preparatory stage of development. To offer clues to such investigations is a psychodynamic task of paramount importance.

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Notes

1 Freud, like Kraepelin before him, called this entity *Zwangsneurose;* by way of different translations, *Zwang* became "obsession" in London and "compulsion" in New York. Subsequent authors, apparently unaware of this fact and eager to ascertain what is meant by "obsessive" and what by "compulsive," settled for the unhappy designation "obsessive-compulsive." The Standard Edition of Freud's work, abides by rendering *Zwangsneurose* as "obsessional neurosis"; hence my term "obsessive behavior."

2 Part A is an abbreviation of the original chapter in the first edition of this handbook. Dr. Rado presented a summary of the adaptational framework which has subsequently been published in detail: Rado, S. *Adaptational Psychodynamics Motivation & Control.* J. Jameson and H. Klein, eds. New York: Science, 1969.

3 The manifestations of defiance were meticulously investigated by David Levy who speaks of them as "oppositional behavior."