The Obsessive & Compulsive Character

*Taken from the book* Psychoanalytic Diagnosis  
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People with personalities organized around thinking and doing about in Western societies.

Pursuing pleasure and attaining pride by thinking and doing are so normative in our society that we scarcely think about the complex implications of their being such esteemed and privileged success.

Where thinking and doing propel someone psychologically, in marked disproportion to feeling, sensing, intuiting, listening, playing, daydreaming, etc, we may infer an obsessive-compulsive character. Many highly productive and admirable people are in this category.

There are also people who are strongly invested in thinking yet who are relatively indifferent to doing, and vice versa.

Obsessive and compulsive tendencies often co-exist in a person, but note that this is a somewhat artificial coupling with respect to character. As *symptoms*, obsessive thought and compulsive behaviors can occur in anyone, not just in those who are characterologically inclined.

- In obsessive-compulsive *disorders*, repetitive thoughts and irresistible actions are *ego-alien*; they disturb the person who has them. In obsessive-
compulsive character structure, they are ego-syntonic; they are often unexamined by the person who has them.

Most behavior that we tend to see as pathological is by definition compulsive: The doer seems driven to act again and again in ways that prove futile or harmful.

DRIVE, AFFECT & TEMPERAMENT

“Anal” issues color the unconscious worlds of people who obsess and act on compulsions.

Freud observed that people he treated for obsessions and compulsions had been pushed toward bowel control prematurely or harshly, or in the context of parental over-involvement.

Subjecting young children to enemas, and intrinsically traumatic procedure, was often rationalized to be in the name of hygiene.

Connections between anality and obsessionality have been supported by research.

The experience of being controlled, judged, and required to perform on schedule creates angry feelings and aggressive fantasies, often about defecation.

- The basic affective conflict in obsessive and compulsive people is rage (at being controlled) vs. fear (of being condemned or punished).

- What is most striking in obsessive-compulsive characters is that affect is unformulated, muted, suppressed, unavailable, or rationalized.

- Obsessive-compulsive characters use words to conceal feelings, not to express them.

If it is seen as reasonable and justified, anger is acceptable to the obsessional person. Righteous indignation is thus tolerable, even admired.

Shame is the other feeling that can penetrated the affectless-ness in obsessive-compulsive characters.

They have high expectations of themselves, project them on to others, and then feel embarrassed to be seen as falling short or their own standards for proper thoughts and deeds.
DEFENSIVE & ADAPTIVE PROCESSES

- The organizing defense of predominantly obsessive people is *isolation of affect*; in compulsive people, the main defensive process is *undoing*.

Higher functioning obsessive individuals prefer more mature versions of separation of affect from cognition: rationalization, moralization, compartmentalization, and intellectualization.

Finally, people of this character style rely heavily on *reaction formation*; and also, *displacement*.

Cognitive Defenses Against Drives, Affects & Wishes

- *Obsessive-compulsive individuals idealize cognition and mental thinking.*

They consign most feelings to a devalued realm associated with childhoodness, weakness, loss of control, disorganization, and dirt.

They are thus at a great disadvantage in situations where emotions, physical sensations, and fantasy have a powerful and legitimate role.

People with obsessive characters are often effective in formal, public roles yet out of their depths in intimate, domestic ones. Although they are capable of loving attachments, they may not be able to express their more tender selves without anxiety and shame.

Consequently, they may turn emotionally toned interactions into oppressively cognitive ones.

They tend to lapse into second-person locutions that are self-distancing. “Well, you feel kind of powerless in those situations.”

The prevalent misconception of the schizoid person as unfeeling may be based on observations of regressed obsessional people who have become wooden and robotic, so deep is the gulf between their cognition and emotion.

Because the distance between an extreme obsession and a delusion is slight, more disturbed obsessional people border on paranoia.
Behavioral Defenses Against Drives, Affects & Wishes

*Undoing is the defining defense mechanism* for the kind of compulsivity that characterizes obsessive and compulsive symptoms and character structure.

Compulsive people undo by actions that gave the unconscious meaning of atonement and/or magical protection.

Compulsivity differs from impulsivity in that a particular action is repeated over and over in a stylized and sometimes escalating way.

Compulsive actions also differ from “acting out”, strictly speaking, in that they are not so centrally driven by the need to master unprocessed past experiences by recreating them.

*Compulsive activity is familiar to all of us.* Whatever one’s compulsive patterns, the disparity between what one feels impelled to do and what is reasonable to do can be glaring.

- *Compulsive activities may be harmful or beneficial; what makes them compulsive is not their destructiveness but their driven-ness.*

Compulsive actions often have the unconscious meaning of undoing a crime, which, in most instances, the compulsive person’s crimes exist mainly in fantasy.

- *Compulsive behavior also betrays unconscious fantasies of omnipotent control.*

This often derives from beliefs that originated early in life, before thoughts and deeds were differentiated. If I think my thoughts and deeds are dangerous, that they are equivalent to powerful actions, I will try to restrain them with a comparably powerful counter-force.

Reaction Formation

The incessant rationality of the obsessional person can be seen as a reaction formation against a superstitious, magical kind of thinking that obsessional defenses do no fully succeed in obscuring.

By insisting on so much control, one is out of control in every significant way.
• Reaction formation is a defense against tolerating ambivalence.

People who are strongly pre-occupied with being upright and responsible may by struggling against more powerful temptations toward self-indulgence than most of us face.

RELATIONAL PATTERNS IN OBSESSIVE & COMPULSIVE CHARACTERS

This character arises from those who have had parental figures who set high standards of behavior and expect early conformity to them.

This character is likely to have had caregivers who tended to be strict, and consistent in rewarding good behavior and punishing bad behavior.

When caregivers are unreasonably exacting, or prematurely demanding, or condemnatory not only of unacceptable behavior but also of accompanying feelings, thoughts, or fantasies, their children’s obsessive and compulsive adaptations can be more problematic.

From an object-relations perspective, what is notable about obsessive and compulsive people is the centrality of issues of control in their families of origin.

Examples - A mother who feeds her child on a schedule, demanded naps to be taken at particular times, inhibited spontaneous motor activities, prohibited masturbation, insisted on conventional sex-role behaviors, punished loose talk, etc.

The frequency of having ‘contamination fears’ in obsessional people is related to separation anxiety that is created by parental over-involvement and over-protection.

Over-protective parents get in the way of a young child’s taking small risks that are necessary to develop a sense of the boundary of self, and accounts for the omnipotent, magical thinking found in obsessive and compulsive people who lack this boundary.

Another kind of family background has been associated with obsessive and compulsive personalities. It is the polar opposite of the over-controlling, moralistic ambiance.
Some people feel so bereft of clear family standards, so unsupervised and casually ignored by the adults around them, that in order to push themselves to grow up – they hold themselves to idealized criteria of behavior and feelings that they derive from the larger culture.

These standards, since they are abstract and not modeled by people known personally to the child, tend to be harsh and unbuffered by a humane sense of proportion.

Many therapists found that patients with the harshest superegos had been the most laxly parented.

- Having to model one’s self after a parental image that one invents by one’s self, especially if one has an intense, aggressive temperament that is projected on to that image, can create obsessive-compulsive dynamics.

THE OBSESSIVE-COMPULSIVE SELF

Introjectively oriented obsessive and compulsive people:

- Are deeply concerned with issues of control and moral rectitude.

- Equate righteous behavior with keeping aggressive, lustful, and needy parts of the self under strict control.

- Tend to be seriously religious, hard-working, self-critical, and dependable.

- Have self-esteem that comes from meeting the demands of internalized parental figures who hold them to a high standard of behavior.

- Worry a lot, especially in situations in which they have to make a choice, and they can be easily paralyzed when the act of choosing has momentous implications.

Paralysis is one of the most unfortunate effects of the reluctance of obsessional people to make a choice.

They have a tendency to postpone decision making until they can see what the “perfect” (guilt and uncertainty free) decision would be.
The client's fear of making the wrong decision and the tendency to cast the process of deciding in purely rationalistic terms (lists of pros and cons) can seduce the therapist into offering an opinion about which choice would be preferable.

If a therapist enters the client's decision-making web, the client will simply and immediately respond with counter-arguments. (Yes buts.)

The "yes, but" stance is an effort to avoid the guilt that inevitably accompanies decisive action.

In standard neurotic fashion, their habitual over-zealousness to preserve their autonomy or sense of agency by avoiding action, in the end, serves to disable it.

Where the obsessive person postpones and procrastinates, the compulsive person speeds ahead.

Compulsive people jump into action before considering alternatives.

- *The compulsive person’s rush to action has the same relationship to autonomy as the obsessive person’s avoidance of action.*

Instrumental thinking and expressive feeling are both circumvented, to avoid the realization that he or she is actually making a choice.

- *Choice involves responsibility for one’s actions, and responsibility involves tolerance of normal levels of both guilt and shame.*

- *Non-neurotic guilt is a natural reaction to exerting power, and a vulnerability to shame comes with the territory of taking deliberate action that can be seen by others.*

Again, remember that obsessive people support their self-esteem by thinking; compulsive one’s by doing.

- *Obsessive and compulsive people fear their own hostile feelings and suffer inordinate self-criticism over both actual and purely mental aggression.*

They value self-control over most other virtues, and emphasize attributes like discipline, order, reliability, loyalty, integrity, and perseverance.
Obsessive and compulsive people are noted for avoidance of affect-laden wholes in favor of separately considered minutia. They are people who hear all the words and none of the music.

TRANSFERENCE & COUNTER-TRANSFERENCE WITH OBSESSIVE & COMPULSIVE CLIENTS

These characters tend to be ‘good clients’. They are serious, conscientious, honest, motivated, and hard-working. Nonetheless, they can have a reputation for being difficult.

- Despite all their dutiful cooperation, they convey an undertone of irritability and criticism.

- They tend to wait impatiently for the therapist to speak and then interrupt before a sentence is finished.

- On a conscious level, they seem utterly unaware of their negativity.

Counter-transference with obsessional clients often includes an annoyed impatience. There is a wish to shake them up, to get them to be open about ordinary feelings, to give them a verbal enema, or insist that they “shit or get off the pot”.

- Their combination of excessive conscious submission and powerful unconscious defiance can be maddening.

Therapists can often feel mystified by the obsessional person’s shame about most emotions and resistance to admitting to them.

Therapists can even feel their rectal sphincter muscle tightening, in identification with the constricted emotional world of the client, and in a real effort to contain a retaliatory wish to “dump” on such an exasperating person.

- The atmosphere of veiled criticism that these characters emit can be discouraging and undermining.

- Clinicians can easily feel bored or distanced by the client’s unremitting intellectualizations, and distancing use of language.
Feelings of insignificance, boredom, and obliteration are relatively rare when working with introjective obsessional clients, but they may vex the therapist who has a more anaclytic obsessive as a client.

- *Doubts about whether anything is being accomplished in therapy are typical for the therapist as well as for the obsessive and compulsive client.*

This is especially true before the person is brave enough to express such concerns directly.

**THERAPEUTIC IMPLICATIONS FOR THE OBSESSIVE & COMPULSIVE**

- *The first rule of practice with obsessive and compulsive people is ordinary kindness.*

They are used to being exasperating to others, and they are grateful for non-retaliatory responses to their irritating qualities.

- *Appreciation for, and interpretation of, their vulnerability to shame is essential.*

Refusal to advise them, hurry them, and criticize them for the effects of their isolation, undoing, and reaction formation will foster movement in therapy. Counter-transference driven power struggles are common between therapists and obsessive clients; they can produce temporary affective movement, but in the long run, they only replicate early object relations.

One must be mindful to avoid becoming the therapeutic equivalent of the demanding, controlling parent, especially as they look to unconsciously evoke this stance from the therapist.

- *One must remember to keep relating warmly to this character.*

Refusing to control the client must be distinguished from attitudes that will be felt as emotionally disengaging from the client. For example, remaining silent with a client who feels pressure or abandonment in silence will be self-defeating.

An exception to the general rule of refusing to advise or control concerns people whose compulsions are outright dangerous.

With self-destructive compulsivity, the therapist has two choices:
1. Tolerate anxiety about what the client is doing until the slow integration of the therapy work reduces the acting out. (Sexual acting out.)

2. At the outset, make the therapy contingent on the client’s stopping the compulsive behavior. (Drug addiction, etc.)

Note that by accepting compulsively self-harming people into therapy unconditionally, the therapist may unwittingly contribute to their fantasies that therapy will operate magically, without their having at some point to exert self-control.

The second position is particularly advisable when the client’s compulsion involves substance abuse; doing therapy with someone whose mental processes are chemically altered is an exercise in futility.

• Many compulsions are not responsive to therapeutic work until the driven person encounters sharp negative consequences.

As long as one is ‘getting away with’ compulsivity, there is little incentive to change.

Why would someone want to continue psychotherapy once a compulsive behavior is under control?

People feel the difference between being able to discipline a compulsion (through will or submission to authority or structure) and not having a compulsion in the first place.

Once a compulsion has stopped, the client can address and work through the issues that drove the compulsion. The client can find a deeper internal security, rather than a tenuous achievement of self-control.

• The second important feature of good work, especially with more obsessive people, is the avoidance of intellectualization.

Any interpretations that only address a cognitive level of understanding, before affective responses have been dis-inhibited, will be counter-productive.

Because it can feel like a power struggle for the therapist to keep asking, “How do you feel?” – a more effective way to bring in affective dimensions is through imagery, symbolism, and artistic communication.

Keep in mind the obsessional people use words to fend off feelings rather than to express them; therefore a more poetic style of speech and representation can be rich and useful.
• The third important component of good work is the practitioner’s willingness to help clients express their anger and criticism about therapy and the therapist.

Obsessive and compulsive clients need ground-laying comments from the therapist that normalize having resentful thoughts about therapy.

These clients will often protest against these ground-laying statements at first, as they can’t imagine being actively dissatisfied and critical.

• The therapist’s position of curiosity towards negative feelings may begin the process of making ego-alien the automatic process of isolating these feelings.

To be useful to obsessive and compulsive clients, one needs not only to help them find and name their affects, but one must also encourage them to enjoy them.

Psychotherapy involves more than just making the unconscious conscious; it requires changing the client’s conviction that what has been made conscious is shameful.

The therapist must also point out the harm being done by not feeling.

*Emotions make one feel alive, energized, and fully human,* even if they express attitudes the client has come to see as ‘bad’.

• Especially with compulsive clients, it is useful to comment on their difficulty tolerating just being, rather than doing.

• Ultimately, the therapist’s quiet dedication to emotional honesty, and the client’s growing experience that he or she will not be judged or controlled, will move the work forward.

Medications and cognitive-behavioral therapies, such as exposure therapy, have become more successful with more severe obsessive-compulsive disorders.

Obsessive and compulsive people with introjective dynamics have a stronger center of gravity psychologically; they are judgmental and self-critical.

• Therefore, a therapist who communicates empathic acceptance of their subjective experience, without evoking the deeper affects and beliefs that shape their experience, is depriving such clients of any empathy worth its name.
DIFFERENTIAL DIAGNOSIS

Ordinarily, obsessive and compulsive dynamics are easy to differentiate from other kinds of characters. *Isolation* and *undoing* are usually pretty visible, along with compulsive organization, since the driven-ness to act cannot be easily masked.

**Obsessive vs Schizoid Personality**

Although a schizoid person withdraws from the outer world, he or she tends to be conscious of intense inner feelings and vivid fantasies. In contrast, a withdrawn obsessional person uses isolation so completely that he or she may be subjectively “blank” or wooden in appearance.