

## SUGGESTIONS FOR FURTHER READING

Reik's (1941) study of moral masochism, though dated, is still worth reading and is not so mired in difficult metapsychology that a beginner would be put off. Stolorow's (1975) essay examines masochism from a self psychology perspective. Cooper's (1988) article on the narcissistic-masochistic character is a classic. Jack and Kerry Kelly Novick (e.g., 1991) have examined the concept developmentally in readable ways. An edited volume on masochism by Glick and Meyers (1988) includes several good essays, most of which concern characterological patterns; *Essential Papers on Masochism* (Hanley, 1995) is also a nice compilation. The books I cited in this chapter by Leon Wurmser (2007) and Sheldon Bach (1999) are both excellent. Finally, I strongly recommend the relational classic by Emmanuel Ghent (1990) for a subtle and wide-ranging exploration of how different the valuable experience of surrender is from masochistic submission.

I did a DVD in the *Master Clinicians* series for the American Psychological Association (McWilliams, 2007) that involved an interview with a patient I saw as having a predominantly masochistic personality. This is available at [www.apa.org/videos](http://www.apa.org/videos).

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## Obsessive and Compulsive Personalities

People with personalities organized around thinking and doing abound in Western societies. The idealization of reason and the faith in progress through human action that were hallmarks of Enlightenment thinking still permeate our collective psychology. Western civilizations, in conspicuous contrast to some Asian and Third World societies, esteem scientific rationality and “can-do” pragmatism above most other attributes. Many individuals thus place the highest value on their logical faculties and their abilities to solve practical problems. 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 activities.

Where both thinking and doing propel someone psychologically, in marked disproportion to feelings, sensing, intuiting, listening, playing, daydreaming, enjoying the creative arts, and other modes that are less rationally driven or instrumental, we may infer an obsessive-compulsive personality structure. Many highly productive and admirable people are in this category. An attorney who loves to construct and deliver legal arguments operates psychologically by reason and action; an environmental activist who derives self-esteem from political involvement may be similarly impelled. Among people so rigidly organized that they meet the DSM criteria for obsessive-compulsive personality disorder, many combine roughly equal amounts of thinking and doing, often in an obviously defensive way. The “workaholic” and the “Type A personality” are popularly acknowledged variations on the obsessive-compulsive theme.

There are also people who are strongly invested in thinking yet who are relatively indifferent to doing, and vice versa. Professors of philosophy sometimes have obsessional but not compulsive character structure; they get pleasure and self-esteem from mentation, and feel no press to implement their ideas. People drawn to carpentry or accounting frequently have compulsive but not obsessive styles; their gratifications come from accomplishing specific and detailed tasks, often with little cognitive elaboration. Some people with no tendencies toward compulsive rituals come to therapists to get rid of intrusive thoughts, and some come with the converse complaint. Because we are so accustomed, after a century of Freudian thinking about the connections between obsessive and compulsive symptoms, to putting the two phenomena together, it is easy to miss the fact that they are conceptually and sometimes clinically separate.

I have followed convention in putting obsessive and compulsive personalities in the same chapter. Obsessive and compulsive trends often coexist in a person, and analytic explorations of their respective origins have revealed similar dynamics. Note, however, that this is a somewhat artificial coupling with respect to character. As *symptoms*, obsessions (persistent, unwanted thoughts) and compulsions (persistent, unwanted actions) can occur in anyone, not just in those who are characterologically obsessive and compulsive. And not all obsessive and compulsive individuals suffer recurrent intrusive thoughts or engage in irresistible actions. We refer to them as obsessive-compulsive because their coping style involves the same defenses that are implicated in obsessive and compulsive symptoms (Nagera, 1976). Complex biological processes are also implicated in obsessive-compulsive disorders, but like many other analysts (e.g., Chessick, 2001; Gabbard, 2001; Zuelzer & Mass, 1994) I feel we have become too reductive in neglecting the psychological side of such conditions simply because we now know more about their biology.

In obsessive-compulsive disorders (in older language, *neuroses*), the repetitive thoughts and irresistible actions are ego alien; they disturb the person who has them. In obsessive-compulsive character structure, they are ego syntonic (D. Shapiro, 2001). Obsessive-compulsive personality has been recognized for a long time as a common or "classic" neurotic-level organization. Salzman (1980) summarizes early observations about obsessive-compulsive psychology as follows:

Obsessive character structures were described by Freud as orderly, stubborn, and parsimonious; others have described them as being obstinate, orderly, perfectionistic, punctual, meticulous, parsimonious, frugal, and inclined to intellectualism and hair-splitting discussion. Pierre Janet

described such people as being rigid, inflexible, lacking in adaptability, overly conscientious, loving order and discipline, and persistent even in the face of undue obstacles. They are generally dependable and reliable and have high standards and ethical values. They are practical, precise, and scrupulous in their moral requirements. Under conditions of stress or extreme demands, these personality characteristics may congeal into symptomatic behavior that will then be ritualized. (p. 10)

He might have added that Wilhelm Reich (1933) depicted them as "living machines," on the basis of their rigid intellectuality (D. Shapiro, 1965). Woodrow Wilson or Hannah Arendt or Martin Buber could be considered representative of a high-functioning person in this diagnostic group, whereas Mark Chapman, whose obsession with John Lennon led to a compulsion to assassinate him, might be seen as at the psychotic end of the obsessive-compulsive continuum.

As was true for masochism as an overall concept, 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. The schizoid person is compelled to avoid people, the paranoid to distrust, the psychopath to use, and so on. Only when *undoing* is prominent is an action compulsive in the narrower sense of an obsessive-compulsive dynamism or a compulsive personality organization.

### DRIVE, AFFECT, AND TEMPERAMENT IN OBSESSION AND COMPULSION

Freud (1908) believed that people who develop obsessive-compulsive disorders were recally hypersensitive in infancy, physiologically and constitutionally. Contemporary analysts question such an assumption, although they may agree with Freud (e.g., Rice, 2004) that there seems to be a genetic contributor to obsessiveness. Still, most would probably say that "anal" issues color the unconscious worlds of people who obsess and act on compulsions. Freud's (1909, 1913, 1917b, 1918) emphasis on fixation at the anal phase of development (roughly 18 months to 3 years), particularly on aggressive urges as they become organized during that period, was novel, seminal, and far less outlandish than debunkers of psychoanalysis would have it.

First, Freud (1908, 1909, 1913) noted that many of the features that typically hang together in people with obsessive-compulsive personalities—cleanliness, stubbornness, concerns with punctuality, tendencies toward withholding—are the salient issues in a toilet-training scenario. Second,

he found anal imagery in the language, dreams, memories, and fantasies of obsessive-compulsive patients. I have found this, too: The earliest memory of one obsessive man I treated was of sitting on the toilet refusing to "produce." When I invited him to free associate, he described himself as "tightening up" and "keeping everything inside."

Third, Freud observed that the people he treated for obsessions and compulsions had been pushed toward bowel control prematurely or harshly or in the context of parental overinvolvement (Fenichel, 1945). (Since the rectal sphincter does not mature until around 18 months, authoritative advice to Western middle-class parents in the early 20th century to start toilet training in children's first year was most unfortunate. It promoted coercion in the name of parental diligence and transformed a benign process of mastery into a dominance-submission contest. If one considers the popularity in that era of subjecting young children to enemas, an intrinsically traumatic procedure usually rationalized in the name of "hygiene," one cannot fail to be impressed with the sadistic implications of the culturally sanctioned rush toward premature anal control.)

Connections between anality and obsessiveness have been supported by empirical research (e.g., Fisher, 1970; Fisher & Greenberg, 1996; Noblin, Timmons, & Kael, 1966; Rosenwald, 1972; Tribich & Messer, 1974) as well as by clinical reports of obsessive-compulsive pre-occupations with the anal issues of dirt, time, and money (Mackinnon, Michels, & Buckley, 2006). Classical formulations about obsessive and compulsive dynamics that center on early body experience are still alive and well (e.g., Benveniste, 2005; Cela, 1995; Shengold, 1988).

Freud reasoned that toilet training usually constitutes the first situation in which the child must renounce what is natural for what is socially acceptable. The responsible adult and the child who is being trained too early or too strictly or in an atmosphere of lurid parental overconcern enter a power struggle that the child is doomed to lose. The experience of being controlled, judged, and required to perform on schedule creates angry feelings and aggressive fantasies, often about defecation, that the child eventually feels as a bad, sadistic, dirty, shameful part of the self. The need to feel in control, punctual, clean, and reasonable, rather than out of control, erratic, messy, and caught up in emotions like anger and shame, becomes important to the maintenance of identity and self-esteem. The kind of harsh, all-or-nothing superego created by these kinds of experiences manifests itself in a rigid ethical sensibility that Ferenczi (1925) wryly called "sphincter morality."

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

But what especially strikes those of us who work with them is that affect is unformulated, muted, suppressed, unavailable, or rationalized and moralized (Mackinnon et al., 2006). Many contemporary writers construe the obsessive allergy to affect as a type of dissociation (e.g., Harris & Gold, 2001).

Obsessive and compulsive people use words to conceal feelings, not to express them. Most therapists can recall instances of asking such a client how he or she felt about something and getting back what he or she thought. An exception to the rule of concealed affect in this diagnostic group concerns rage: If it is seen as reasonable and justified, anger is acceptable to the obsessional person. Righteous indignation is thus tolerable, even admired; being annoyed because one did not get what one wanted is not. Therapists frequently feel the presence of normal reactive anger in an obsessive person, but the patient typically denies it—despite sometimes being able to acknowledge intellectually that some behavior (forgetting the check for the third time, or interrupting the therapist in mid-sentence, or pouting) could denote a passive-aggressive or hostile attitude.

Shame is the other exception to the general picture of affectlessness in obsessive-compulsive people. They have high expectations for themselves, project them onto the therapist, and then feel embarrassed to be seen falling short of their own standards for proper thoughts and deeds. Shame is generally conscious, at least in the form of mild feelings of chagrin, and if gently treated, can usually be named and investigated by the therapist without the protest and denial that may be evoked by efforts to explore other feelings.

### DEFENSIVE AND ADAPTIVE PROCESSES IN OBSESSION AND COMPULSION

As the preceding paragraphs imply, the organizing defense of predominantly obsessive people is isolation of affect (Fenichel, 1928). In compulsive people, the main defensive process is undoing. Those who are obsessive and compulsive employ both isolation and undoing. Higher-functioning obsessional people do not usually use isolation in its most extreme forms; they instead prefer more mature versions of the separation of affect from cognition: rationalization, moralization, compartmentalization, and intellectualization. Finally, people in this clinical group rely heavily on reaction formation. Obsessional people at all developmental levels may also use displacement, especially of anger, in circumstances in which by diverting it from its original source to a "legitimate" target, they can own such a feeling without shame.

DW/ED  
phd  
Shengold

### Cognitive Defenses against Drives, Affects, and Wishes

Obsessive-compulsive individuals idealize cognition and mentation. They tend to consign most feelings to a devalued realm associated with childishness, weakness, loss of control, disorganization, and dirt. (And sometimes femininity; men with obsessive and compulsive personalities may fear that expressing tender emotions regresses them to an early, disowned, premasculine identification with Mother.) They are thus at a great disadvantage in situations where emotions, physical sensations, and fantasy have a powerful and legitimate role. The widow who ruminates ceaselessly about the details of her husband's funeral, keeping a stiff upper lip and converting all mourning into frenetic busyness, not only fails to process her grief effectively but also deprives others of the consolations of offering comfort. Obsessional people in executive positions deny themselves adequate release and recreation, and hurt their employees by making drivenness the company rule.

People with obsessive characters are often effective in formal, public roles yet out of their depth in intimate, domestic ones. Although they are capable of loving attachments, they may not be able to express their tenderer selves without anxiety and shame; consequently, they may turn emotionally toned interactions into oppressively cognitive ones. In therapy and elsewhere, they may lapse into second-person locutions when describing emotions ("How did you feel when the earthquake hit?") "Well, you feel kind of powerless"). Not every human activity should be approached from the standpoint of rational analysis and problem solving. One man with whom I did an intake interview responded to my question about the quality of his sexual relationship with his wife with the somber assertion, "I get the job done."

Obsessional people in the borderline and psychotic ranges may use isolation so relentlessly that they look schizoid. 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. I have been told that in the era before antipsychotic medication, a common way to differentiate between an extremely rigid, nonpsychotic obsessive-compulsive person and a barely defended paranoid schizophrenic was to put the patient into a protected room and emphasize that now he or she was safe. Thus invited to suspend obsessional defenses, a schizophrenic person would begin to talk about paranoid delusions, whereas an obsessive-compulsive one would set about cleaning the room.

### Behavioral Defenses against Drives, Affects, and Wishes

Undoing is the defining defense mechanism for the kind of compulsivity that characterizes obsessive and compulsive symptoms and personality structure. Compulsive people undo by actions that have 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. Finishing the food on our plate when we are no longer hungry, cleaning the house when we should be studying for an exam, criticizing someone who offends us even though we know it will have no effect other than making an enemy, throwing "just one more" quarter into the slot machine. 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 drivenness. Florence Nightingale was probably compulsively helpful; Jon Stewart may be compulsively funny. People rarely come to treatment for their compulsivity if it works on their behalf, but they do come with related problems. Knowing that these clients are organized compulsively can aid us in helping them with whatever they are looking to do in therapy.

Compulsive actions often have the unconscious meaning of undoing a crime. Lady Macbeth's handwashing is a famous literary example of this dynamic, though in her case the crime had actually been committed. In most instances, the compulsive person's crimes exist mainly in fantasy. One of my patients, a married oncologist who knew very well that AIDS is not easily transmitted by mouth-to-mouth contact, felt helplessly compelled to get tested repeatedly for HIV antibodies after she had kissed a man with whom she was tempted to have an affair. Even some compulsions that are manifestly free of a sense of guilt can be found to have originated in guilt-inducing interactions; for example, most people who compulsively clean their plates were made to feel guilty as children about rejecting food when, somewhere in the world, people are starving.

Compulsive behavior also betrays unconscious fantasies of omnipotent control. This dynamic is related to preoccupations with one's presumed crimes in that a determination to control, like the need to undo, derives from beliefs that originated before thoughts and deeds were differentiated. If I think my fantasies and urges are dangerous, that they are equivalent to powerful actions, I will try to restrain them with a compa-

rably powerful counterforce. In prerational cognition (primary process thought), the self is the center of the world, and what happens to oneself is the result of one's own activity, not the chance twists of fate. The baseball player who performs a ritual before each game, the priest who gets anxious if he left something out of a prayer, the pregnant woman who keeps packing and repacking her suitcase for the hospital—all think at some level that they can control the uncontrollable if only they do the right thing.

### Reaction Formation

Freud believed that the conscientiousness, fastidiousness, frugality, and diligence of obsessive-compulsive people were reaction formations and against wishes to be irresponsible, messy, profligate, and rebellious, and that one could discern in the overresponsible style of such individuals a hint of the inclinations against which they struggled. The incessant rationality of the obsessional person, for example, can be seen as a reaction formation against a superstitious, magical kind of thinking that obsessional defenses do not fully succeed in obscuring. The man who stubbornly insists on driving even though he is exhausted betrays the conviction that averting an accident depends on his being in charge of the car, not on a combination of an alert driver and some good fortune. In insisting on so much control, he is out of control in every significant way.

In Chapter 6 I talked about reaction formation as a defense against tolerating ambivalence. In working with obsessive and compulsive people, one is struck by their fixation on both sides of conflicts between cooperation and rebellion, initiative and sloth, cleanliness and slovenliness, order and disorder, thrift and improvidence, and so forth. Every compulsively organized person seems to have at least one messy drawer. Paragons of virtue may have a paradoxical island of corruption: Paul Tillich, the eminent theologian, had an extensive pornography collection; Martin Luther King Jr. was a womanizer. People who are strongly preoccupied with being upright and responsible may be struggling against more powerful temptations toward self-indulgence than most of us face; if this is so, it should not surprise us when they are only partially able to counteract their darker impulses.

### RELATIONAL PATTERNS IN OBSESSIVE AND COMPULSIVE PSYCHOLOGIES

One route by which individuals emerge with obsessive and compulsive psychologies involves parental figures who set high standards of behavior

and expect early conformity to them. Such caregivers tend to be strict and consistent in rewarding good behavior and punishing malfeasance. When they are basically loving, they produce emotionally advantaged children whose defenses lead them in directions that vindicate their parents' scrupulous devotion. The traditional American child-rearing style documented in McClelland's (1961) classic studies of achievement motivation tends to produce obsessive and compulsive people who expect a lot of themselves and have a good track record for realizing their goals.

When caregivers are unreasonably exacting, or prematurely demanding, or condemnatory not only of unacceptable behavior but also of accompanying feelings, thoughts, and fantasies, their children's obsessive and compulsive adaptations can be more problematic. One man I worked with had been raised in a stern midwestern Protestant family of deep religious conviction but shallow emotional capacity. His parents hoped he would become a minister and began working on him early to forgo temptation and banish all thoughts of sin. This message gave him no trouble—in fact, he found it easy to imagine assuming the morally elevated role into which they were so eager to cast him—until he reached puberty and found that sexual temptation is not nearly so abstract a danger as it had previously seemed. From then on, he overdosed with self-criticism, conducted incessant rationalistic ruminations about sexual morality, and launched heroic efforts to counteract erotic feelings that another boy would have simply learned to enjoy and master.

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. Whereas Freud (1908) depicted the anal phase as engendering a prototypical battle of wills, people with an object relations perspective emphasize that the parent who was unduly controlling about toilet training was probably equally controlling about oral- and oedipal-phase issues (and subsequent ones, for that matter). The mother who laid down the law in the bathroom is likely to have fed her child on a schedule, demanded that naps be taken at particular times, inhibited spontaneous motor activity, prohibited masturbation, insisted on conventional sex-role behavior, punished loose talk, and so on. The father who was forbidding enough to provoke regressions from oedipal to anal concerns was probably also reserved toward his infant, stern with his toddler, and authoritarian with his school-age child.

Mearns (2001), citing research about the frequency of contamination fears in obsessional people in disparate cultures (e.g., India, Japan, Egypt), relates them to separation anxiety that is created by parental overinvolvement and overprotection. Rooting his observations in the-

retical and empirical literature about cognitive development, he argues that overprotective parents get in the way of a young child's taking the 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 in terms of the lack of this boundary.

There is a version of obsessive and compulsive personality that is more introjective, or self-definition oriented, and one that is more anachronic, or self-in-relation oriented (Blatt, 2008). The Freudian obsessive-compulsive (Freud, 1913) was definitely the former. When I refer to "traditional" or "old-fashioned" obsessive and compulsive dynamics, I am referring to a guilt-dominated psychology, which was common in Freud's era and culture. It can be found in many contemporary cultures and subcultures but now seems rarer in mainstream North American communities. In those, about which I say more shortly, we tend to see obsessive behaviors that are more shame based, more focused on looking perfect to others rather than responding to one's morally perfectionistic internal gyroscope. In the first edition of this book, I followed Kernberg's (1984) formulation that the second type is a subset of narcissistic personalities, but another way of construing less guilt-prone obsessive-compulsive people is as having an anachronic version of obsessional psychology.

In old-fashioned obsessive-compulsive-breeding families, control may be expressed in moralized, guilt-inducing terms, as in "I'm disappointed that you were not responsible enough to have fed your dog on time," or "I expect more cooperative behavior from a big girl like you," or "How would you like it if somebody treated you that way?" Moralization is actively modeled. Parents explain their own actions on the basis of what is right ("I don't enjoy punishing you, but it's for your own good"). Productive behavior is associated with virtue, as in the "salvation through work" theology of Calvinism. Self-control and deferral of gratification are idealized.

There are still many families that operate this way, but in Western industrialized cultures, pop-Freudian ideas about the inhibiting effects of too moralistic an upbringing, in combination with 20th-century dangers and cataclysms that suggest the wisdom of "getting it while you can" rather than postponing gratification, have changed child-rearing practices. We see fewer obsessive and compulsive people of the morally preoccupied type common in Freud's day. Many contemporary families that emphasize control foster obsessive and compulsive patterns through shaming rather than guilt induction. Messages like "What will people think of you if you're overweight?" or "The other kids won't want to play with you if you behave like that," or "You'll never get into an Ivy League college if you don't do better" have, according to many clinicians

and societal observers, become more common messages in the West than communications stressing the primacy of individual conscience and the moral implications of one's behavior.

It is important to appreciate this change if one is working with more contemporary obsessive and compulsive psychopathologies such as eating disorders (not that anorexia and bulimia nervosa were unknown at the turn of the century, but they were almost certainly less prevalent). Freudian accounts of compulsion are insufficient in accounting for anorectic and bulimic compulsivity; post-Freudian writers drawing on object relations theory and on research on attachment, addiction, and dissociation have provided more clinically useful formulations (e.g., Bromberg, 2001; Pearlman, 2005; Sands, 2003; Tison & Rothschild, 2009; Yarock, 1993).

Another kind of family background has been associated with obsessive and compulsive personality and, as is typical in psychoanalytic observation, it is the polar opposite of the overcontrolling, moralistic ambience. 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 feeling 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. One of my patients, for example, whose father was a melancholy alcoholic and whose mother was overburdened and distracted, grew up in a house where nothing ever got done. The roof leaked, the weeds proliferated, the dishes sat in the sink. He was deeply ashamed of his parents' ineptitude and developed an intense determination to be the opposite: organized, competent, in control. He became a successful tax advisor, but a driven workaholic who lived in fear that he would betray himself as a fraud who was somehow in essence as ineffectual as his father and mother.

Early psychoanalysts noted with great interest the phenomenon of obsessive-compulsive character in underparented children; it challenged Freud's (1913) model of superego formation, which postulates the presence of a strong and authoritative parent with whom the child identifies. Many analysts were finding that their patients with the harshest superegos had been the most laxly parented (cf. Beres, 1958). They concluded that having to model oneself after a parental image that one invents oneself, especially if one has an intense, aggressive temperament that is projected into that image, can create obsessive-compulsive dynamics. Later, Kohut (1971, 1977, 1984) and other self psychologists made similar observations from the standpoint of their emphasis on idealization.

## THE OBSESSIVE-COMPULSIVE SELF

Introjectively oriented obsessive and compulsive people are deeply concerned with issues of control and moral rectitude. They tend to define the latter in terms of the former; that is, they equate righteous behavior with keeping aggressive, lustful, and needy parts of the self under strict rein. They are apt to be seriously religious, hard-working, self-critical, and dependable. Their self-esteem comes from meeting the demands of internalized parental figures who hold them to a high standard of behavior and sometimes thought. They 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 portentous implications. Anaclitically oriented obsessive individuals worry a lot, too, though the focus of their concern is more external: The "perfect" decision is one that no witness can criticize.

This paralysis is one of the most unfortunate effects of the reluctance of obsessive people to make a choice. Early analysts christened this phenomenon the "doubting mania." In the effort to keep all their options open, so that they can maintain (fantasied) control over all possible outcomes, they end up having no options. An obsessive-compulsive woman I know, on becoming pregnant, lined up two different obstetricians who worked at two different medical centers with opposing philosophies about childbirth. All through her pregnancy she ruminated about which person and which facility was preferable. When she went into labor, not having resolved this question, it took her so long to decide whether her condition warranted going to the hospital, and which hospital it should be, that she was suddenly in the later stages of giving birth and had to go to the nearest clinic and be delivered by the resident on duty. All her painstaking obsessing was rendered futile when reality finally enforced its own resolution of her ambivalence.

Her experience exemplifies the tendency of obsessively structured people to postpone decision making until they can see what the "perfect" (i.e., guilt and uncertainty free) decision would be. It is common for them to come to therapy trying to resolve ambivalence over two boyfriends, two competing graduate programs, two contrasting job opportunities, and the like. The client's fear of making the "wrong" decision and tendency to cast the process of deciding in purely rationalistic terms—lists of pros and cons are typical—often seduce the therapist into offering an opinion about which choice would be preferable, at which point the patient immediately responds with counterarguments. The "Yes, but" stance of the obsessive person may be seen as, at least in part, an effort to avoid the guilt that inevitably accompanies action. Obsessive people often postpone and procrastinate until external circumstances like the

rejection by a lover or the passing of a deadline determine their direction. In standard neurotic fashion, then, their overzealousness to preserve their autonomy or sense of agency serves eventually to disable it.

Where the obsessive person postpones and procrastinates, the compulsive one speeds ahead. People with compulsive psychologies have a similar problem with guilt or shame and autonomy, but they solve it in the opposite direction: They jump into action before considering alternatives. For them, certain situations have "demand characteristics" requiring certain behaviors. These are not always foolish (like knocking on wood every time one makes an optimistic prediction) or self-destructive (jumping into bed every time a situation becomes sexually tinged); some people are compulsively helpful (McWilliams, 1984). Some drivers will risk their own safety and wreck their cars before hitting an animal, so automatic is their compulsion to preserve life.

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 lest the person notice 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. Both obsessive and compulsive people may be so saturated with irrational guilt and/or shame that they cannot absorb any more of these feelings.

As I mentioned earlier, obsessive people support their self-esteem by thinking: compulsive ones by doing. When circumstances make it hard for obsessive or compulsive individuals to feel good about themselves on the basis of what they are figuring out or accomplishing, respectively, they become depressed. Losing a job is a disaster for almost anybody, but it is catastrophic for compulsive individuals because work is often the primary source of their self-esteem. I do not know if we have any research on this yet, but I assume that people with the guilt-ridden version of obsessive and compulsive dynamics are subject to more introjective depressions, with an actively bad (uncontrolled, destructive) self-concept gaining ascendancy, and that shame-prone obsessive and compulsive clients suffer more anaclitic depressive reactions (see Chapter 11).

Obsessive and compulsive people fear their own hostile feelings and suffer inordinate self-criticism over both actual and purely mental aggression. Depending on the content of their family's messages, they may be equally nervous about giving in to lust, greed, vanity, sloth, or envy. Rather than accepting such attitudes and basing their self-respect or self-condemnation solely on how they behave, they typically regard even feeling such impulses as reprehensible. Like moral masochists, with

whom they share tendencies toward overconscientiousness and indignation, introjective obsessive patients may nurture a kind of private vanity about the stringency of their demands on themselves. They value self-control over most other virtues and emphasize attributes like discipline, order, reliability, loyalty, integrity, and perseverance. Their difficulties in suspending control diminish their capacities in areas like sexuality, play, humor, and spontaneity in general.

Finally, obsessive-compulsive people are noted for avoidance of affect-laden wholes in favor of separately considered minutia (D. Shapiro, 1965). People with obsessional psychologies hear all the words and none of the music. In an effort to bypass the overall import of any decision or perception, the appreciation of which might arouse guilt, they become fixed on specific details or implications ("What if ...?"). On the Rorschach test, obsessional subjects avoid whole percept responses and expound on the possible interpretations of small particulars of the inkblots. They cannot (unconsciously, will not) see the forest for the proverbial trees.

### TRANSFERENCE AND COUNTERTRANSFERENCE WITH OBSESSIVE AND COMPULSIVE PATIENTS

Obsessive and compulsive people tend to be "good patients" (except toward the lower end of the severity continuum, where the rigidity of their isolation of affect or the driving immediacy of their compulsions interfere with therapeutic collaboration). They are serious, conscientious, honest, motivated, and hard-working. Nonetheless, they have a reputation for being difficult. It is typical for obsessional clients to experience the therapist as a devoted but demanding and judgmental parent, and to be consciously compliant and unconsciously oppositional. Despite all their dutiful cooperation, they convey an undertone of irritability and criticism. When a therapist comments on possible negative feelings, they are usually denied. As Freud (1908) originally noted, obsessional patients tend to be subtly or overtly argumentative, controlling, critical, and resentful about parting with money. They wait impatiently for the therapist to speak and then interrupt before a sentence is completed. And at a conscious level, they seem utterly innocent of their negativity.

Thirty-five years ago I treated a man for severe obsessions and compulsions. Today I might send him for concurrent exposure therapy and possibly medication; at the time, those treatments had not been developed. He was an engineering student from India, lost and homesick in an alien environment. In India, deference to authority is a powerfully rein-

forced norm, and in engineering, compulsivity is adaptive and rewarded. But even by the standards of these comparatively obsessive and compulsive reference groups his ruminations and rituals were excessive, and he wanted me to tell him definitively how to stop them. When I reframed the task as understanding the feelings behind his preoccupations, he was visibly dismayed. I suggested that he might be disappointed that my way of formulating his problem did not permit a quick, authoritative solution. "Oh, no!" he insisted; he was sure I knew best, and he had only positive reactions to me.

The following week he came in asking how "scientific" the discipline of psychotherapy is. "Is it like physics or chemistry, an exact science?" he wanted to know. No, I replied, it is not so exact and has many aspects of an art. "I see," he pondered, frowning. I then asked if it troubled him that there is not more scientific accuracy in my field. "Oh, no!" he insisted, absentmindedly straightening up the papers on the end of my desk. Did the disorder in my office bother him? "Oh, no!" In fact, he added, it is probably evidence that I have a creative mind. He spent our third session educating me about how different things are in India, and wondering abstractedly about how a psychiatrist from his country might work with him. Did he sometimes wish I knew more about his culture, or that he could see an Indian therapist? "Oh, no!" He is very satisfied with me.

His was, by clinic policy, an eight-session treatment. By our last meeting, I had succeeded, mostly by gentle teasing, in getting him to admit to being occasionally a little irritated with me and with therapy (not angry, not even aggravated, just slightly bothered, he carefully noted). I thought the treatment had been largely a failure, though I had not expected to accomplish much in eight meetings. But 2 years later he came back to tell me that he had thought a lot about feelings since he had seen me, particularly about his anger and sadness at being so far from his native country. As he had let in those emotions, his obsessions and compulsions had waned. In a manner typical of people in this clinical group, he had found a way to feel that he was in control of pursuing insights that came up in therapy, and this subjective autonomy was supporting his self-esteem.

Countertransference with obsessional clients often includes an annoyed impatience, with wishes to shake them, to get them to be open about ordinary feelings, to give them a verbal enema or insist that they spit or get off the pot.<sup>\*</sup> Their combination of excessive conscious submission and powerful unconscious defiance can be maddening. Therapists who have no personal inclination to regard affect as evidence of weakness or lack of discipline are mystified by the obsessional person's shame about most emotions and resistance to admitting them. Some-

times, one can even feel one's rectal sphincter muscle tightening, in identification with the constricted emotional world of the patient (concordant), and in a physiological effort to contain one's retaliatory wish to "dump" on such an exasperating person (complementary).

The atmosphere of veiled criticism that an obsessive-compulsive person emits can be discouraging and undermining. In addition, clinicians easily feel bored or distanced by the client's unremitting intellectualization. With one obsessive-compulsive man I treated, I used to find myself having a vivid image that his head was alive and talking, but his body was a life-sized cardboard cutout like the ones amusement parks provide for customers to put their heads through to be photographed. Feelings of insignificance, boredom, and obliteration are relatively rare when one works with introjective obsessional clients, but they may vex the therapist of a more anacritically obsessive person. Hearing endless ruminations about whether one should do the Atkins or the South Beach diet, buy a poodle or a beagle, go by taxi or by foot can be aggravating.

There is something very object related about the unconscious devaluation of the more guilt-ridden obsessive-compulsive patients, something touching about their efforts to be "good" in such childlike ways as cooperating and deferring. Doubts about whether anything is being accomplished in therapy are typical for the therapist as well as for the obsessive or compulsive client, especially before the person is brave enough to express such worries directly. But underneath all the obstinacy of the obsessional individual is a capacity to appreciate the therapist's patient, noncondemnatory attitude, and as a result, it is not hard to maintain an atmosphere of basic warmth.

### THE THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF OBSESSIVE OR COMPULSIVE PERSONALITY

The first rule of practice with obsessive and compulsive people is ordinary kindness. They are used to being exasperating to others, for reasons they do not fully comprehend, and they are grateful for nonretaliatory 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 more movement in therapy than more confronting measures. Countertransference-driven power struggles are common between therapists and obsessional clients; they produce temporary affective movement, but in the long run they only replicate early and detrimental object relations.

At the same time that one carefully avoids the therapeutic equivalent of becoming the demanding, controlling parent, one needs to keep relating warmly. The degree of therapist activity will depend on the client—some obsessional people will not let the clinician get a word in edgewise until the last moments of a session, while others become disorganized and frightened if one remains quiet. Refusing to control should be distinguished from attitudes that will be felt as emotional disengagement. Remaining silent with a person who feels a pressure in silence is self-defeating, as is silence with a patient who feels abandoned when he or she is not addressed. Asking the patient's direction on how much the therapist should speak, like other respectful inquiries about what is helpful, may resolve the therapist's problem while supporting the client's sense of agency, human equality, and realistic control.

An exception to the general rule of refusing to advise or concern people whose compulsions are outright dangerous. With self-destructive compulsivity, the therapist has two choices: either tolerate anxiety about what the patient is doing until the slow integration of the therapy work reduces the compulsion to act, or, at the outset, make therapy contingent on the client's stopping the compulsive behavior. An example of the former would be hearing about one driven sexual affair after another while nonjudgmentally analyzing the dynamic involved, until the patient becomes unable to rationalize the defensive use of sexuality. An advantage of this position is its implicit encouragement of honesty (if one sets behavioral conditions for therapy, the patient will be tempted to hide it if he or she cheats). When the person's self-destructiveness is not life threatening, I think this choice is usually preferable.

Examples of the latter would include requiring that an addict go through detox and rehab before starting psychotherapy, insisting that a dangerously anorexic client first gain a given number of pounds in a hospital-supervised regime, or making therapy of an alcohol abuser conditional on attendance at AA meetings. When undoing is automatic, the wishes, urges, and fantasied crimes being undone will not surface. Moreover, by accepting compulsively self-harming people into treatment unconditionally, the therapist may unwittingly contribute to their fantasies that therapy will operate magically, without their having at some point to exert self-control. This position is particularly advisable when the patient'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 treatment until the driven person encounters sharp negative consequences. Shoplifters and pedophiles tend to get serious about therapy only after they have been arrested;

addicts often have to "bottom out" before getting help; cigarette smokers rarely try to stop before they get scared about their health. As long as one is "getting away with" compulsivity, there is little incentive to change. The reader may wonder why anyone would want to go through psychotherapy once the compulsive behavior is under control. The answer is that people feel strongly the difference between being able to discipline a compulsion (by efforts of will or submission to authority) and not having one in the first place. Therapy with someone who has stopped behaving compulsively allows that person to master the issues that drove the compulsion, and to find internal serenity rather than a tenuous achievement of self-control. The alcoholic who feels no more need to drink is in a lot better shape than the one who, through constantly reinforced efforts of will, can manage to stay sober despite temptation (Levin, 1987). Individuals in recovery from compulsion are also helped by understanding why they were vulnerable to addictive behavior.

The second important feature of good work with people in this diagnostic group, especially the more obsessional ones, is the avoidance of intellectualization. Interpretations that address the cognitive level of understanding, before affective responses have been disinhibited, will be counterproductive. I suspect we have all known people in psychoanalytic therapy who can discuss their dynamics in the tone of an auto mechanic detailing what is wrong with someone's motor, and who appear not a bit better for all this knowledge. It was experience with obsessive-compulsive people that infused analytic clinical theory with warnings about the dangers of premature interpretation (e.g., Glover, 1955; Josephs, 1992; Strachey, 1934) and comments on the difference between intellectual and emotional insight (e.g., Kris, 1956; Richfield, 1954).

Because it can feel like a power struggle (to both parties) for the therapist to keep harping on the question "But how do you *feel*?" one way to bring a more affective dimension into the work is through imagery, symbolism, and artistic communication. Hammer (1990), in exploring how obsessional people use words more to fend off feeling than to express it, mentions the special value to this population of a more poetic style of speech, rich in analogy and metaphor. With extremely constricted patients, the combination of group therapy (where other clients tend to attack the isolative defense head-on) and individual treatment (where the therapist can help the person to process such experiences privately) is sometimes therapeutic (Yalom & Leszcz, 2005).

A third component of good treatment with obsessionally and compulsively structured people is the practitioner's willingness to help them express their anger and criticism about therapy and the therapist. Usually one cannot accomplish this right away, but one can pave the way for the patient's eventual acceptance of such feelings by preparatory com-

ments such as "It can be exasperating that the therapy process does not work as fast as we would both want it to. Don't be surprised if you find yourself having resentful thoughts about coming here or about me. If you were to notice you were feeling dissatisfied with our work, would anything get in the way of your telling me that?" A frequent response to these ground-laying comments is a protest that the client cannot imagine being actively dissatisfied and critical. The therapist's position that such a statement is very curious may begin the process of making ego alien the automatic process of isolation.

To be useful to obsessive and compulsive people, one needs not only to help them find and name their affects but also to encourage them to enjoy them. Psychoanalytic therapy involves more than making the unconscious conscious; it requires changing the patient's conviction that what has been made conscious is shameful. Behind this susceptibility to shame lie pathogenic beliefs about sinfulness that propel both obsessive and compulsive mechanisms. That one could enjoy a sadistic fantasy, not just own up to it, or derive comfort from grieving, not just admit grudgingly that one is sad, may be news to these clients. The sharing of the therapist's sense of humor may lighten the guilt and self-criticism that weigh so heavily on them.

"What good will it do to feel that?" is a frequent query of individuals with obsessive and compulsive psychologies. The answer is that harm is being done in *not* feeling it. Emotions make one feel alive, energized, and fully human, even if they express attitudes that the patient has come to see as "not very nice." Especially with compulsive patients, it is useful to comment on their difficulty tolerating just *being*, rather than doing. It is no accident that 12-step programs, in their efforts to arrest self-destructive compulsivity, discovered the Serenity Prayer. Occasionally, one can appeal to the practical nature of obsessive and compulsive people when they flee their feelings; for example, some scientifically minded patients find it helpful to know that crying rids the brain of certain chemicals associated with chronic mood disturbances. If these patients can rationalize expressiveness as being something other than pathetic self-indulgence, they may risk it sooner. But ultimately, the therapist's quiet dedication to emotional honesty, and the patient's growing experience that he or she will not be judged or controlled, will move the work forward.

Via medications such as the selective serotonin reuptake inhibitors (SSRIs), and CBT techniques such as exposure, many people with obsessive-compulsive disorder are now being helped more than psychoanalytic therapy alone could help them previously. In those who have obsessive-compulsive personality, with ego-syntonic ruminations and compulsions, those approaches seem to be less effective. This observa-

NOTE

tion parallels what I said in Chapter 11 about characterologically depressive patients, who seem less responsive to the drugs that mitigate major depression or dysthymia than individuals who suffer a depression but whose personality structure is not depressive. Nonetheless, many analytic therapists (e.g., Lieb, 2001) working with clients with obsessive and compulsive personalities report increased effectiveness when they combine dynamic psychotherapy with both pharmacological and cognitive-behavioral interventions.

## DIFFERENTIAL DIAGNOSIS

Ordinarily, obsessive and compulsive dynamics are easy to differentiate from other kinds of psychology. Isolation and undoing are usually pretty visible; compulsive organization is particularly conspicuous, since the person's drivenness to act cannot be easily masked. Still, some kinds of confusion occur. Obsessive structure is sometimes hard to distinguish from schizoid psychology, especially at the lower-functioning end of the developmental continuum, and from narcissistic personalities with obsessive defenses. Sometimes it can be hard to differentiate obsessive and compulsive dynamics from organic brain syndromes.

### Obsessive versus Narcissistic Personality

In Chapter 8 I discussed narcissistic versus obsessional character structure, with an emphasis on the damage done when an essentially narcissistic person is misunderstood as obsessive or compulsive, when the therapist accordingly looks for unconscious anger, omnipotent fantasies, and guilt rather than subjective emptiness and fragile self-esteem. The damage is probably less serious when a mistake is made the other way, since all of us, whatever our character, can profit from therapies that focus on issues of self. Nevertheless, an old-fashioned, moralistic obsessive or compulsive person being treated by someone who construes him or her as narcissistic would be eventually distressed, demoralized, and even insulted by being seen as needy rather than conflicted.

Obsessive and compulsive people with introjective dynamics have a strong center of gravity psychologically; they are judgmental and self-critical. A therapist who communicates empathic acceptance of their subjective experience without evoking the deeper affects and beliefs that shape that experience is depriving such patients of any empathy worth its name. Sometimes interventions that a therapist conceives as mirroring are received by obsessive and compulsive clients as corrupting, in that

the patient views the therapist as implicitly condoning aspects of the self that the patient sees as indefensible. Under these circumstances patients begin to doubt the moral credentials of the therapist. Analysis of the rationalistic and moralistic defenses of obsessive and compulsive clients should precede efforts to convey acceptance of the troublesome feelings these defenses have been erected to conceal.

### Obsessive versus Schizoid Personality

In the symbiotic-psychothic range, some people who look schizoid may be in fact regressed obsessional patients. 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. Knowledge of the premorbid functioning of someone for whom this differential applies will provide clues about whether to communicate to the patient that it is safe to express his or her intense inner experience, or to convey that it must be terrible to feel so cold and dead inside.

### Obsessive-Compulsive versus Organic Conditions

This book does not cover psychopathology of organic origin, but I should note the frequency with which inexperienced interviewers—whether or not they have had medical training—misconstrue behavior related to brain damage as obsessive-compulsive. The perseverative thinking and repetitive actions typical of organic brain syndromes (Goldstein, 1959) can mimic "functional" obsessiveness and compulsivity, but dynamically informed questioning will reveal that isolation of affect and undoing are not involved. A good history, with inquiries about possible fetal alcohol syndrome or maternal addiction during pregnancy, complications at birth, illnesses with high fever (meningitis, encephalitis), head injury, and so forth may suggest an organic diagnosis, which may be confirmed by neurological examination.

Not all brain damage involves loss of intelligence. The practitioner should not assume that because a person is bright and competent, he or she could not suffer from organically based difficulties. This is a critical differential, since therapy to uncover unconscious dynamics in order to reduce a client's obsessive-compulsive inflexibility may be radically different from treatment that emphasizes, to the organically damaged person and to his or her family, the value of maintaining order and predictability for the sake of the client's emotional security and comfort.

## SUMMARY

I have discussed in this chapter people who preferentially think and/or act, in order to pursue emotional safety, reduce anxiety, maintain self-esteem, and resolve internal conflicts. I reviewed classical conceptions of obsessive-compulsive character structure, with emphasis on Freud's (1908, 1909, 1913, 1931) formulations about the centrality of anal-phase issues in its development and related struggles over unconscious guilt and fantasies of omnipotence. I differentiated that version of the phenomenon from more anacletic manifestations of obsessive-compulsive psychology. I noted that defensive processes in obsessive and compulsive people (isolation and undoing, respectively, and reaction formation in both) suppress or distract from most affects, wishes, and drives, but unconscious guilt (over hostility) and conscious susceptibility to shame (over falling short of standards) are easily inferred. Family histories of people in this group are notable for either overcontrol or lack of control; current relationships tend to be formal, moralized, and somewhat juiceless, despite the basic capacity for attachment that obsessive-compulsive people demonstrate.

I also addressed obsessive-compulsive perfectionism, ambivalence, and avoidance of guilt by either procrastination or impulsivity and noted that transference and countertransference issues center around noticing and absorbing the patient's unconscious negativity. Therapeutic inferences include being unhurried, avoiding power struggles, discouraging intellectualization, inviting anger and criticism, and modeling the enjoyment of devalued feelings and fantasies. I differentiated obsessive and compulsive personalities from schizoid patients, from narcissistically structured people with perfectionistic and compulsive defenses, and from those with organic brain syndromes.

## SUGGESTIONS FOR FURTHER READING

Probably the most readable book on this topic is Salzman (1980). D. Shapiro's (1965) naturalistic study of the obsessive-compulsive personality style remains a classic; and his 1984 and 1999 books followed it up with interesting chapters on obsessive and compulsive rigidity.

Shengold's *Hallo in the Sky* (1988) offers a brilliant exploration of anality as a concept and metaphor. The second issue of the journal *Psychoanalytic Inquiry* in 2001 (Bristol & Pasternack, 2001) contains many relevant essays, some of which I have cited in this chapter, mostly about obsessive-compulsive disorder but touching on obsessive-compulsive personality and the evaluation of psychoanalytic ideas about it in the context of recent research on neuroscience.

## Hysterical (Histrionic) Personalities

Psychoanalysis began with the effort to understand hysterical conditions and has returned to that problem regularly since the 1880s, when Freud first tackled it. Inspired by the work of the French psychiatrists Charcot, Janet, and Bernheim, who were investigating hysterical affections via hypnosis, Freud first began asking the kinds of questions that gave psychoanalytic theory its shape: How can someone know and not know at the same time? What accounts for forgetting important experiences? Does the body express what the mind cannot fathom? What would explain such sensational symptoms as full epileptic-like seizures in a person without epilepsy? Or blindness in someone optically normal? Or paralysis when nothing is wrong with the nerves?

At the time, hysterically ill women were being thrown out of physicians' offices as malingerers. Whatever Freud's mistakes about female psychology or sexual trauma, it is to his credit that he took these women seriously and paid them the respect of trying to understand their particular suffering. By doing so, he believed he would begin comprehending processes that operate in the emotionally healthy as well as in the emotionally disabled. Although this chapter is not about the dramatic disturbances that were in Freud's day subsumed under the rubric of hysterical neurosis (conversion, amnesia, inexplicable attacks of anxiety, and other disparate phenomena), I review some psychoanalytic history relevant to those conditions in the service of eventually focusing on the personality structure that often accompanies them.