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11

The Obsessional Personality

Persons of obsessional personality are those who are prone to develop obsessional, or compulsive symptoms. These take the form of unwanted thoughts which intrude upon the patient's consciousness; or of ritual actions which the patient feels himself to have to carry out against his will. Every psychiatrist in training will soon see a number of examples of patients with obsessional neuroses, ranging in severity from mild compulsions to check and re-check to states of severe disablement in which the patient's existence is dominated by rituals to such an extent that normal life is impossible. This latter group of patients are not really suitable for psychotherapy. Rituals can be looked upon as a displacement activity, or a form of 'acting out'; and many have to be brought under control by other methods before psychotherapy can be attempted.

Since the advent of behaviour therapy, various techniques have been employed to help the patient control or abolish ritual behaviour like compulsive hand-washing, or rid his mind of intrusive thoughts: and these techniques may sometimes be a useful alternative to psychotherapy in the case of overt, clear-cut obsessional symptoms. However, as in previous chapters, I shall not be concerned primarily with the therapy of symptoms, but with understanding the obsessional as a whole person. This is especially important in the case of obsessional patients, since the line between pathology and normality is often hard to draw. If a man feels obliged to check ten times before he can get on

with what he wants to do next, we label him neurotic. Writers ought to be meticulous in their use of words; but there is something wrong with those who, like Dorothy Parker, say 'I can't write five words but that I change seven.'[1] However, the majority of obsessional patients who come the way of the psychotherapist exhibit traits and behaviour which are no more than slight exaggerations of traits and behaviour which are highly valued; scrupulosity, reliability, self-control, honesty, being some examples. They seek psychotherapy because of tension and anxiety, or because of difficulties in interpersonal relationships, not because of compulsive rituals, although these may be present as minor features of their complaints.

When Freud described the personalities of those who tend to develop obsessional symptoms, he described them as 'noteworthy for a regular combination of the three following characteristics. They are especially *orderly*, *parsimonious* and *obstinate*.'[2] Found together, these traits constituted what Freud named the 'anal' character since he believed that they took origin from the period at which the child was being taught control of his sphincters, during which the anal region was the focus of emotional concern. In Freud's view, 'Cleanliness, orderliness and trustworthiness give exactly the impression of a reaction-formation against an interest in what is unclean and disturbing and should not be part of the body. ("Dirt is matter in the wrong place.")' Obstinacy may first be manifested in the child's refusal to excrete in the right place at the right time as indicated by those in authority. Parsimony arises because of a peculiar connection between money and faeces; 'filthy lucre', being one example of such a connection. Today, we would be likely to think of parsimony in more general terms, as a reluctance to part with bodily contents or anything which is felt intimately to belong to the self.

Efforts to prove that the 'anal' character is causally connected with harsh toilet-training or particular conflicts during the time of acquiring sphincter control have not been successful; but many investigations have demonstrated that, whilst his hypothesis as to cause may be wrong, Freud's description of the anal character, and his perception that certain traits are found together, is accurate. (See Fisher and Greenberg[3].)

Whatever the causal origin of the 'anal', obsessional personal-

ity, there can be no doubt of the emphasis which such persons put upon control and order. Like all obsessional traits, the drive toward attaining order and control is Janus-faced: that is, when present in moderation, it is valuable, indeed, essential to the more complex pursuits of civilised life. When exaggerated, it is destructive of spontaneity, and may eventually paralyse action. In previous chapters, we saw that hysterics often feel of no account, and depressives both helpless and hopeless. Obsessionals actively defend themselves against such feelings, and strive to master both themselves and the external world. At the same time, they behave as if some unspecified disaster was about to overtake them. Mastery of oneself, and to some extent of one's environment, is something which we all teach our children as desirable, and which we hope they will increasingly attain as they grow up. But we also have to accept that our control can never be complete. In the external world, accidents will happen, whether these be of the order of earthquakes or tornadoes, or merely the minor mishaps of day-to-day life. Nor can we entirely control ourselves, however fiercely we discipline our unruly minds and bodies. Even if we dislike the processes, we must needs excrete and eat; and, in the case of the majority, sex is so urgent a drive that it, too, cannot entirely be subdued. Much of our mental life, from dream to inspiration, is beyond the reach of the will. We have to fit in with our own natures, just as we do with those of other people; and the idea that control over ourselves can ever be absolute is illusory.

Many people with obsessional traits of personality are not in any sense 'ill'. Indeed, such people are indispensable to Western civilisation, and are thus accorded admiration and respect. Intellectuals, whether in the sciences or the humanities, are commonly of obsessional personality. Research and scholarship demand meticulous exactness. The obsessional person's ideal is that the world shall be an ordered place in which everything without exception is predictable. Such also is the vision of the scientist. The progress of science depends upon the invention of hypotheses which, by bringing an ever-increasing number of facts into causal relation with each other, impose order upon chaos, and enable more and more accurate predictions to be made. It is the discernment of anomalies, of facts not covered by the existing hypotheses, which leads to new discoveries and

new theories. Anomalies are a form of disorder which spur the scientist on to create a more comprehensive order; just as dirt or other forms of disorder may impel an obsessional neurotic to arrange and re-arrange his room.

The sense of unrest, even of irritation, which provokes the scientist to invent a new hypothesis cannot be called a neurotic symptom; and even some obsessional rituals hardly deserve the name. Is the child who demands that his parent shall tell him the same story, arrange his bedclothes in a particular way, kiss him goodnight in exactly the same fashion behaving pathologically? Such ritual observances are symbolic protections against the dangers of the dark in which the child feels threatened both from without and from within. It is easy to dismiss ritual practices as superstition; but this is to undervalue their significance and effectiveness. As I pointed out in *The Dynamics of Creation*,[4] rituals are often valuable to creative people as means whereby they are put into touch with the sources of inspiration, just as religious rituals serve the purpose of inducing an appropriate state of mind in the worshipper. Man is man because he uses symbols and rituals to transmute the raw stuff of instinct into intellectual and artistic creations. The fact that symbolisation and ritualisation can become exaggerated to the point at which an obsessional neurotic is dominated by them as symptoms should not blind us to their vital significance in civilised life.

Obsessional personalities, for a variety of possible reasons, have an especially strong propensity toward control both of themselves and their environment. For them, as for the child who fears the dark, both the external world and the inner world of their own minds are places of danger. Only perpetual vigilance and unrelenting discipline can ensure that neither get out of hand. In the IXth book of *The Republic* Socrates says that 'in all of us, even in good men, there is a lawless wild-beast nature, which peers out in sleep'. Obsessionals behave as if the beast was straining at the leash. Moreover, they are apt to behave as if other people were similarly constituted; as if the world, therefore, was a jungle in which the unseen hosts of Midian are for ever on the prowl.

The wild beast which obsessionals fear is principally an aggressive animal. Although sexual impulses often constitute a

part of the forces which obsessionals are trying to control, aggression plays a larger part than love in their psychology. Instead of perceiving other people as persons with whom that can relate on equal terms, each providing the other with reciprocal benefit, obsessionals tend to relate in terms of domination versus submission, or superiority versus inferiority. This way of relating to people can be interpreted as a persistence of a childhood attitude; a relic of a time in which parents, however loving, were also perceived as authorities who were inevitably restrictive and who might become angry unless placated. As soon as the developing child begins to come into conflict with his parents (and this conflict may well be particularly manifest if the parents themselves are of obsessional temperament), his attitude toward them is necessarily ambivalent; that is, a mixture of love and hate. The weaker the child feels himself to be in relation to authority, or the more dominant that authority is in fact, the more will resentment equal or outweigh the love he feels. In his paper *The Disposition to Obsessional Neurosis*, Freud made the interesting suggestion that, in such people, emotional development and intellectual development were somehow out of phase. 'I suggest,' he wrote, 'the possibility that a chronological outstripping of libidinal development by ego development should be included in the disposition to obsessional neurosis. A precocity of this kind would necessitate the choice of an object under the influence of the ego-instincts, at a time at which the sexual instincts had not yet assumed their final shape, and a fixation at the stage of the pregenital sexual organization would thus be left'. (See Freud[5].) This statement will not be clear to those not steeped in the technical language of psychoanalysis, so I will try to put it another way. Many, though not all, persons of obsessional disposition show precocious intellectual development in childhood. This is especially true of the type of intellectual mentioned earlier. When such a child perceives his parents as restrictive authorities, he learns to relate to them by means of his intelligence rather than emotionally. That is, he becomes intensely and precociously aware of what they are feeling, in order to placate them and avoid their displeasure. Instead of battling with them, and gradually learning to assert his own power or prove his own equality, such a child need never enter into competition. This means that he will continue

to regard parents, and adults in general as superior in power to himself, and also that he will carry into adult life a greater than usual quantity of resentment towards other people. An adaptation towards others which involves treating them as if they were authorities who might suddenly become angry must necessarily involve the persistence of aggressive feelings toward them, and the exercise of considerable control over such feelings. In adult life, obsessionals tend either to be authoritarian themselves, or else unduly submissive. Either attitude is one in which the object is to disarm the other party. Faced with possible hostility, one either conquers or submits. In neither case can one achieve equality and mutual respect.

Obsessionals entering psychotherapy often appear to be especially mild, compliant characters who are anxious to please the therapist and agree too easily with everything which he may propose. Fear of aggression from others dominates their adaptation to their fellows. They are usually carefully and neatly dressed, in order to forestall any possible criticism of their appearance. They are punctilious in keeping appointments for which they often arrive early. They show gratitude toward the therapist before he has had time to do anything to help them, and are overanxious about causing him any possible inconvenience. Obsessionals of this type make admirable bank clerks and secretaries. I remember that in my first psychiatric post one such secretary rang me up before completing his typing of a letter I had dictated. Had I said 'Yours truly', or 'Yours faithfully'? I could not remember; but he was anxious to be precisely accurate. A man I saw recently who exhibited many features of this temperament told me that he paid all his bills in shops with cash. Otherwise he might find that he was keeping other customers waiting whilst he wrote a cheque; and this, of course, might make them annoyed. The same man, whose job was to check certain lists which others made out in the factory in which he worked, was extremely good at detecting errors. But it was torture to him to have to point out these errors to those who had perpetrated them; they might be distressed or angry. It is this kind of person who, if one steps on his toe, apologises for inconveniencing one.

Obsessionals of this type share many characteristics with depressives, and indeed often become depressed themselves

when their obsessional defences are undermined by some factor which increases their anxiety. Whereas this type of obsessional is primarily concerned with warding off the aggression of other people, there is another type who is more concerned with controlling his own. When his defences fail, he becomes naggingly critical, and may be extremely difficult to live with. Tense, irritable, obsessional parents who want to keep everything under tight control extend this wish to those with whom they live. They insist upon cleanliness and tidiness; upon locking doors, being polite, keeping up appearances, not offending the neighbours. For such people, living in a family is difficult. They may be able so to order their own behaviour that they have no feeling that things will 'get out of hand', but they cannot entirely control the behaviour of other people. Their anxiety leads to anger; and it is small wonder that their wives and children rebel against what they feel to be an irrational tyranny. It is easy to see, therefore, that the obsessional person's failure to integrate or control his aggressive impulses may lead in one of two directions; toward submission, on the one hand, or toward tyranny on the other. Extreme submission leads almost to his disappearance as a separate entity. Extreme tyranny leads to the disappearance of the other, and hence to isolation. This is why we can interpret obsessional defences as being erected against both depressive and against schizoid states. If he stays close to people he either becomes overtly angry with them because he cannot entirely control them; or else turns his anger against himself and so becomes depressed.

Alternatively, he may detach himself from people. It is quite possible to live with a family and yet be uninvolved emotionally. This type of defence is schizoid; a retreat into isolation so that one cannot be affected by people. If one is unaffected, one cannot either be angry or suffer the anger of others.

Personalities of this kind who develop overt symptoms usually show evidence of aggression in their symptomatology. Thus, compulsive, intrusive thoughts tend to be of the pattern described in the chapter on interpretation, in which a woman had the thought that she might boil her baby. Some obsessionals cannot ascend to a high place, or even travel on top of a bus without entertaining the thought that they might drop something on passers-by. Clergymen, whose profession requires that

they be more habitually kind and understanding than they can always manage, not infrequently fear that swear-words or obscenities will escape their lips at inappropriate moments, as when they are preaching. Housewives may anxiously feel compelled to put all food which they serve to their families through a sieve, in case some minute particle of broken glass might do someone an injury. Such symptoms represent a failure of defence in that the repressed, underlying aggressiveness of the subject is allowed to peep through.

The psychotherapist's task with such people is twofold. First, he must facilitate the emergence of the instinctive impulses against which the patient is defending himself. Second, he must present himself as a person with whom the patient can experiment in trying to reach a new kind of relationship on more equal terms; a relation in which the question of who is dominant and who submissive is no longer crucial.

Obsessional patients are generally described as difficult subjects for psychotherapy because of their capacity for intellectualisation. Since their whole defensive system is one designed not to allow the free expression of emotion, they find it hard to 'let go' during psychotherapy as they do in other situations in life. If they have, as children, been precocious intellectually in the way already described, they will bring this kind of adaptation to people into the therapeutic situation. That is, they will be anxious to understand exactly what the utterances of the therapist mean. Very often they will accept his interpretations and explanations of their psychology as likely to be reasonable without giving any indication that these have struck home in the kind of way which might bring about modification. Obsessionals tend to understand with their heads rather than with their hearts. Since intelligent patients of this type are often expert with words, they use words not as expressing their true feelings but as a way of distancing themselves from them. And so when the therapist says something which might be expected to produce outrage: 'You must have wanted to *murder* your mother!' the patient mildly replies: 'Perhaps you're right. I suppose something of the kind must be involved.'

Such patients become much more accessible when they are depressed. It is often helpful to pick on any tiny instance of spontaneous reaction to the therapist in the here-and-now,

since this may give access to the spontaneous feelings which the patient tries so hard to control. It is also useful to explore dreams, since these may be the quickest way of demonstrating to a patient that he has another side to him which he is trying to suppress and banish. Some obsessional patients find that they can 'let go' better through the medium of painting and drawing than by using only words.

Of all patients, obsessionals are the most likely to persist in psychotherapy even without much evidence of improvement. Compliant, grateful, and hopeful – at least on the surface – they are regarded by the therapist as 'good' patients with whom he enjoys working. It is part of the obsessional's problem that he tends to live in the future rather than in the present. His habit of anticipating danger leads him to take all sorts of precautions about the future and to be preoccupied with it to the exclusion of the present. As I wrote elsewhere, obsessionals at the threatre may be so preoccupied with imagining how they are going to get home that they fail to appreciate the performance itself. The same tendency makes them able to look forward to the effects of psychotherapy in the future, without participating fully in the therapeutic relation in the present. I think it probable that some of the analyses lasting years and years which have been described represent obsessionality on both sides; on the part of the therapist as well as the patient.

I wrote above that obsessionals actively defend themselves against depression or other unpleasant states of mind. A good example of such a person was Samuel Johnson. In Boswell's *Life of Johnson* references to his obsessional rituals and compulsive movements are scattered: but the neurologist, Russell Brain, assembled these together with other descriptions of Johnson's behaviour by his contemporaries into an essay 'The Great Convulsionary' which may be found in Lord Brain's book, *Some Reflections on Genius*.[6]

Boswell wrote: 'He had another particularity of which none of his friends ever ventured to ask an explanation. It appeared to me some superstitious habit, which he had contracted early, and from which he had never called upon his reason to disentangle him. This was his anxious care to go out or in at a door or passage, by a certain number of steps from a certain point, or at least so as that either his right or his left foot (I am not certain

which), should constantly make the first actual movement when he came close to the door or passage. Thus I conjecture; for I have, upon innumerable occasions, observed him suddenly to stop, and then seem to count his steps with a deep earnestness; and when he had neglected, or gone wrong in this sort of magical movement, I have seen him go back again, put himself in a proper posture to begin the ceremony, and, having gone through it, break from his abstraction, walk briskly on, and join his companion.'[7]

Johnson's gestures and movements when his attention was not engaged were so extraordinary as to arouse suspicion that he was suffering from chorea or some other organic disease of the nervous system. He also talked to himself, sometimes audibly uttering parts of the Lord's Prayer. However, as Lord Brain observes, the fact that he could control both his movements and his speech when he had to do so demonstrates that these bizarre symptoms were caused by psychological conflict rather than by organic disease. Sir Joshua Reynolds, to whom Johnson sat for his portrait, wrote: 'These motions or tricks of Dr Johnson are improperly called convulsions. He could sit motionless, when he was told to do so, as well as any other man; my opinion is that it proceeded from a habit which he had indulged himself in, of accompanying his thoughts with certain untoward actions, and those actions always appeared to me as if they were meant to reprobate some part of his past conduct. Whenever he was not engaged in conversation, such thoughts were sure to rush into his mind; and for this reason, any company, any employment whatever, he preferred to being alone. The great business of his life (he said) was to escape from himself; this disposition he considered as the disease of his mind, which nothing cured but company.'[8] Another observer explains Johnson's talking to himself in similar fashion. 'He seemed to struggle almost incessantly with some mental evil, and often, by the expression of his countenance and the motion of his lips appeared to be offering up some ejaculation to Heaven to remove it.'[9]

We know against what Johnson was defending himself by his obsessional rituals, and what kind of thoughts he was attempting to expel from his mind. Johnson was subject to recurrent depression; what he himself called 'a vile melancholy', and was plagued by guilt. All his life he suffered the fear of insanity. He

hated going to bed because, once alone, morbid thoughts were sure to plague him. He was preoccupied with death and said that he never had a moment in which death was not terrible to him. He condemned himself for indolence, for having sensual thoughts, for indulgence in food and drink. In one passage he says, 'I have lived totally useless.'[10] Johnson is a fascinating and sad example of a man who kept depression at bay with obsessional defences during most of his life; but whose defences failed at times so that he was precipitated into a slough of despond. It is interesting that Johnson prescribed intellectual activity for a fellow-sufferer who was plagued with guilt. He himself turned to arithmetical calculations in order to divert himself; an early example of what behaviour therapists might call 'thought stopping'.

The psychotherapist who treats obsessional patients of the kind who are referred for psychotherapy will find them intensely interesting, but may become discouraged by their lack of immediate response. However, if he sees the relatives of such patients, he may find that he is producing more result than he knows. Obsessional personalities do alter and improve; but because of their self-control do not necessarily show much direct evidence of this to the psychotherapist. The psychotherapist's aim is that the patient shall be able to drop his defence sufficiently for him to be able to be spontaneous, at any rate intermittently. This is why 'here-and-now' interpretations are so important. Every risk which the patient is able to take in the psychotherapeutic situation is a step forward. When a frank obsessional neurosis is present, in which compulsive rituals form a major part of the problem, behavioural techniques of treatment should be considered. As I shall discuss later, behaviour therapy may be more appropriate in cases in which parts of the patient's behaviour have to be brought under control.

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