

A CRITICAL COMPARISON AND EVALUATION  
OF THE CLASSICAL ETIOLOGICAL FORMULA  
AND THE KLEINIAN VIEWPOINT ON OBSESSIONAL NEUROSIS

BY

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Contents	Page
Acknowledgements	i
Abstract	1
CHAPTER 1 INTRODUCTION AND AIMS	3
1.1 Introduction	3
1.2. Review of the psychoanalytic explanations of obsessional neurosis.	5
1.2.1. The classical etiological formula	5
1.2.2 The 'obsessional neurosis or constellation as a defense' viewpoint.	7
1.2.3 The 'culturalist approach' to obsessional neurosis.	10
(a) Rado's Mother-child battle	10
(b) Laughlin's eclectic approach	12
(c) The parental empathy deficit.	13
1.3 Aim and rationale of the study	16
1.3.1 Practical considerations.	17
1.3.2 Theoretical considerations.	20
CHAPTER 2 PSYCHIATRIC CONSIDERATIONS	24
2.1 Definition	24
2.1.1 The symptomatology of obsessional neurosis.	25
2.2 Epidemiology	27
2.3 Onset, course and prognosis.	27
2.3.1 Onset	27
2.3.2 Course and prognosis.	29
2.4 Differential diagnosis.	30
2.4.1 Organic states	30
2.4.2 Phobic neuroses	30
2.4.3 Depression	31

	page
2.4.4 Schizophrenia	32
2.4.5 The obsessional personality	33
CHAPTER 3 THE CLASSICAL ETIOLOGICAL FORMULA OF OBSESSIONAL NEUROSIS	 35
3.1 The phenomenology of obsessional neurosis	36
3.1.1 Neurotic symptoms and language	36
3.1.2 Obsessional symptoms and the two-step theory of defence.	37
3.1.3 Psychoanalytic and psychiatric taxonomies.	44
3.2 The change from early trauma theory.	45
3.3 Obsessional neurosis and the anal-sadistic libidinal organisation	 47
3.3.1 The sexual drive and the bodily source	48
3.3.2 The anal-sadistic organisation	51
3.3.3 The anal or anankastic personality traits	52
3.3.4 Faeces - money - gift - penis - baby	53
3.3.5 Sexual ambivalence and the anal-sadistic organisation	55
3.3.6 Aggression and ambivalence	56
3.4 The Oedipus Complex and the fixation-regression hypothesis	 56
3.4.1 The Oedipus Complex and the castration complex	57
3.4.2 The fixation-regression hypothesis in obsessional neurosis	61
3.5 The consequences of regression on the super-ego in obsessional neurosis.	 67
3.6 The ego in obsessional neurosis	71
3.6.1 ego modifications in obsessional neurosis	72
3.6.2 The precocity of ego development	75
3.7 The ego-mechanisms of defence	76
3.7.1 Repression	77

3.7.2	Reaction-formation	78
3.7.3	Isolation	78
3.7.4	Symbolic undoing	79
3.8	The age of onset and the course of obsessional neurosis	80
3.9	Obsessional neurosis, the infantile neurosis and transference neurosis.	82

CHAPTER 4 KLEIN'S WRITINGS ON OBSESSIONAL NEUROSIS AND THE PSYCHOTIC ANXIETY-SITUATIONS OF THE FIRST YEAR OF LIFE 87

4.1	Chronology of M. Klein's writings on obsessional neurosis	87
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4.2	Early psychotic anxieties	91
4.2.1	The concept of position	91
4.2.2	Drive dualism	92
4.2.3	The internal, external and real object psychical reality	94

4.3	The paranoid-schizoid position	96
4.3.1	The 'good' and 'bad' breast	97
4.3.2	Persecutory anxiety, splitting, idealisation and omnipotent denial of psychical reality	98
4.3.3	Projective identification	100

4.4	The depressive position	104
4.4.1	Ambivalence and the whole object	104
4.4.2	Depressive anxiety	105
4.4.3	The manic defences	107
4.4.4	Omnipotent reparation and reparation proper	109

4.5	The early Oedipus Complex	111
4.5.1	Klein's divergence from Freud	112
4.5.2	The early Oedipus Complex and the combined parental figure	113
4.5.3	The little boy's and little girl's Oedipus Complex.	117

WB  
Theme VIII

	page
4.6 Summary	119
<b>CHAPTER 5 OBSESSIONAL MECHANISMS AND OBSESSIONAL NEUROSIS</b>	<b>121</b>
5.1 Obsessional symptoms, mechanisms and neurosis: Definition	121
5.2 The infantile neurosis: animal phobias and obsessional mechanisms	122
5.2.1 The infantile neurosis and obsessional mechanisms	122
5.2.2 Early phobias and obsessional mechanisms	124
5.3 Obsessional mechanisms	127
5.3.1 The reaction formations: orderliness, cleanliness, disgust and pity.	127
5.3.2 The mechanism of compulsive accumulation and giving.	130
5.3.3 The obsessional coercion of others.	133
5.3.4 Omnipotent destruction and omnipotent reparation	135
5.3.5 The obsessional desire for knowledge	139
5.4 Obsessional mechanisms, obsessional neurosis and age of onset.	141
5.5 Obsessional neurosis and psychosis	143
5.6 The early super-ego and obsessional neurosis	145
<b>CHAPTER 6 CRITICAL COMPARISON BETWEEN THE CLASSICAL ETIOLOGICAL FORMULA AND THE KLEINIAN VIEWPOINT ON OBSESSIONAL NEUROSIS</b>	<b>149</b>
6.1 The regression hypothesis and the Oedipus Complex	149
6.2 The age of onset and the anal-sadistic fixation	154
6.3 Rita, Erna and the Rat-Man.	157

	page
6.4 Klein's obsessional mechanisms and Freud's ego defences.	162
6.5 The anal-sadistic fixation and the anal phase	167
PART II CLINICAL STUDY	
CHAPTER 7 THE CASES OF ALAIN AND ADELE	171
7.1 Aims	171
Case I : "The Dogged archer and his absent ... dog"	173
7.2 Clinical history	173
7.2.1 Presenting problem	173
7.3 Psychodynamic analysis	177
7.3.1 Onset and the infantile neurosis	177
7.3.2 The drive regression and the overall clinical picture	181
7.3.3 Anal-sadistic symbolism	185
7.3.4 The rescuer: the sausage dog in green and gold	187
7.3.5 The sublimation of his anal-sadistic libido	189
7.3.6 The status of sports in Alain's psychical life	190
7.3.7 The ego, its strengths and defences	192
7.3.8 The super-ego	193
7.4 Case II : "Adele's lament : my-mother-my-self"	196
7.4.1 Essential features of the psychiatric history	196
7.5 Discussion and psychodynamic evaluation	202
7.5.1 Early childhood 'obsessions' : Adele, Erna, Alain	202
7.5.2 The ego structure and its defences	204
7.5.3 The ego and its obsessional defences	211
7.5.4 The archaic features of the super-ego	213

	page
CHAPTER 8 SUMMARY AND CONCLUSIONS	216
8.1 The age of onset	219
8.2 The dominance of the anal-sadistic fixation	220
8.3 The ego structure and the ego defence mechanisms	221
8.4 The quality of the super-ego	222
REFERENCES	224

#### ABSTRACT

This study aims at exploring and explicating a latent controversy in the psychoanalytic literature between the 'classical etiological formula' and the Kleinian viewpoint on obsessional neurosis. The classical formula, which comprises Freud's original theses and subsequent contributions, is comprehensively reviewed and its particular depiction of the internal structure of obsessional neurosis is spelt out. Klein's writings on the topic, although they enjoy a definite status amongst certain contemporary writers, have never before been properly systematised.

The comparison suggests that major contradictions exist between the two viewpoints. It is argued that Klein's emphasis on the fundamental role of obsessional mechanisms, upon which an obsessional neurosis is built, is tantamount to a major etiological shift away

from the centrality assigned to the phallic Oedipus Complex, and the regression thereof, by the 'classical etiological formula'.

This contradiction entails various consequences which are investigated. One prominent empirical consequence is the earliest age of onset of obsessional neurosis. A critical examination of the existing psychiatric and psychoanalytic literature on this topic lends support to the classical formula. It is put forward that Kleinian theory best articulates the notion of an obsessional configuration which acts as a defence against psychotic disturbances.

Two case studies are presented to illustrate the clinical applicability and relevance of each viewpoint. The importance of a psychodynamic evaluation of obsessional symptomatology is emphasised.

## CHAPTER I

### 1.1 INTRODUCTION

In the wake of the 1965 International Congress of Psycho-Analysis (Amsterdam), organised around the theme of obsessional neurosis (I.J.P.A., 1966), Humberto Nagera wrote an extensive review of the psychoanalytic literature in which he makes the following startling points: "It may come as a surprise that relatively few contributions in relation to obsessional neuroses are to be found in the psychoanalytic literature. In fact the bibliography on the subject, considering its importance, is rather limited ...", and he adds: "... it was difficult to find much that was truly original. Much of the literature consists of repetitions, elaborations, or confirmations of Freud's (and a few others) points of view" (Nagera, 1976 : 73).

The psychoanalytic investigation of obsessional neuroses occupies an important place in the history of psychoanalysis (Jones, 1964; Laplanche and Pontalis, 1973). Obsessional neurosis as a distinct nosological category was first isolated by Freud himself (Freud, 1896). However, up to Freud's publication of his famous Rat-Man case (Freud, 1909), psychoanalytic theorising had been dominated by its interest in that other transference neurosis: hysteria. With the study of obsessional neurosis, significant advances were made in various aspects of psychoanalytic theory. To name a few: the formulation of the anal-sadistic libidinal organization (Freud, 1908) added significantly to the theory of psycho-sexual development; the theory of the ego-defences

received a fresh boost since repression, which plays an important role in hysteria, only partly accounts for symptom-formation in obsessional neurosis (Freud, 1926; Fenichel, 1946). The theory of the Oedipus Complex and super-ego formation (Freud, 1910; 1923(b); 1924; 1926) equally derived a significant input from the elucidation of that particular field of psychopathology. General psychoanalytic theory is strongly indebted to the study of obsessional neurosis. Nagera's sense of surprise in the light of the paucity of original and significant post-Freudian contributions is thus understandable.

However, Nagera's second point as regards the repetitive, confirmatory, and at best mildly elaborative contributions is a contentious one. It may lead to the view that, on the whole, this particular area of study is pervaded by a consensus of opinion which, in the main, does not significantly depart from the original Freudian hypotheses. Although it is true that the "classical etiological formula" (refer to Ch. 3) is the dominant paradigm (Laplanche and Pontalis, 1973; A. Freud, 1966; Nagera, 1976), the psychoanalytic literature on obsessional neuroses comprises divergent theoretical viewpoints and approaches (Nagera, 1976; A. Freud, 1966; Adams, 1973). Of those, some are complementary to the 'classical etiological formula', whilst others are fundamentally challenging of its central theoretical tenets. In order to elucidate the present contention, three broad psychoanalytic explanatory approaches to obsessional neurosis will be briefly reviewed.

Such a review addresses itself to broad types of explanatory hypotheses put forward by psychoanalytic writers. The aim of the review is not to provide exhaustive coverage of the myriad of psychoanalytic writings on the subject. A comprehensive review of this sort has been effectively undertaken by Nagera (1976). Rather its aim is

to clarify, justify and define the specific focus of the present thesis which consists of a critical comparison and evaluation of the 'classical' and Kleinian viewpoints on obsessional neurosis.

The review is based on: (i) Nagera's comprehensive "obsessional neuroses" (1976); (ii) Adams' book, entitled "Obsessive Children" (1973); (iii) the various papers presented at the 1965 International Congress of Psycho-Analysis (I.J.P.A., 1966) organised on the theme of obsessional neurosis, and (iv) Gabe's report on the preparatory panel of the American Psychoanalytic Association on obsessional neurosis ( Gabe, 1965).

## 1.2 REVIEW OF THE PSYCHOANALYTIC EXPLANATIONS OF OBSESSIONAL NEUROSIS.

### 1.2.1 The Classical Etiological Formula

The classical etiological formula (referred to as the classical formula or viewpoint hereafter) refers essentially to the original Freudian hypotheses on the topic (Freud, 1896; 1908; 1909; 1913; 1923(a); 1926). Two broad groups of contributors adhere to the classical viewpoint. On the one hand, classical Freudians such as Jones (1913; 1918), Fenichel (1945), Alexander (1948), and Nunberg (1955) reiterate and refine Freud's original insights. On the other hand, the Hampstead Clinical group led by Anna Freud and Humberto Nagera, usually identified with a psychoanalytic ego-psychology, equally subscribe to the classical viewpoint. Although the Hampstead team is known for their theoretical commitments to the structural category of the ego, their position as regards obsessional neurosis is essentially Freudian (A. Freud, 1965, 1966; Nagera, 1976; Tolpin, 1970; Sandler and Joffe, 1965).

The classical viewpoint will be fully reviewed in Chapter 3. Here, its main tenets are briefly examined.

The dominant feature of obsessional neurosis is the drive regression, an ego-defence mechanism, from the phallic-oedipal to the anal-sadistic libidinal organization. As a consequence of this regression, the quality of id impulses warded off from consciousness are the pre-genital, ambivalent anal-sadistic urges. A formidable array of ego-defences are mobilised against such ego-dystonic impulses, which leads to the emergence of symptom formations with a distinctive obsessional quality. The ego-defences, which operate strictly within the area of the thought processes, are namely: denial, repression, reaction formation, isolation, intellectualisation, symbolic doing and undoing, and rationalisation (S. Freud, 1923, 1926; A. Freud, 1966; Nagera, 1976).

Obsessional neurosis is considered to be a transference neurosis. This term implies that the conflicts and resolution of the phallic-oedipus complex play a leading etiological and organizing role in the constitution of the neurosis. It also implies that the ego in obsessional neurosis retains an adequate relationship with reality and with its objects (Tolpin, 1970; Eissler, 1954). Obsessional neurosis thus finds its place in the neurotic pole of the neurosis-psychosis continuum although obsessional neurosis may manifest various degrees of severity.

The various aspects of this highly succinct account will be extensively developed in Chapter 3. Contributions from various Freudians and ego-psychology authors will be included where relevant.

1.2.2 The "obsessional neurosis or constellation as a defence" viewpoint.

This viewpoint is not a systematic one. Nor is it the prerogative of any particular psycho-analytic school. It is a 'loose' view which permeates the psychoanalytic writings of a variety of authors (Nagera, 1976). Its most unifying theme is a dissatisfaction with the etiological tenets of the classical formula, and with the view of obsessional neurosis as a transference neurosis. Instead obsessional organizations or obsessional neuroses are considered to constitute a defence against more fundamental psychotic disturbances.

It is generally accepted that obsessional 'constellations' extend from the "ego-syntonic and near normal - during development, in character formation - to the status of an extremely severe neurotic disturbance, bordering occasionally on the schizoid and schizophrenic proper" (A. Freud, 1966 : 116). Abraham (1924) observed that, in their 'free' interval, patients suffering from manic-depressive psychosis exhibit "the same characteristics as psychoanalysis has made us acquainted with in obsessional neurosis - the same peculiarities in regard to cleanliness and order ..." (Abraham, 1924 : 423).

At the 1965 Amsterdam Congress, B. Joseph attempted to show how, during the course of the analysis of a four-year-old patient, one could watch the development from a paranoid to an obsessional organization: "These obsessional techniques, defensive, precautionary, controlling and magical, extended to cover the main areas of his relationship and his thinking, and would then dominate the clinical picture" (Joseph, 1966 : 90). Joseph, herself a renowned Kleinian analyst, invoked the writings of M. Klein on the relation between paranoid

and obsessional disturbances (Joseph, 1966 : 184).

G. Bychowsky showed how, in his analysis of borderline patients, "a relatively large group displays obsessive compulsive symptomatology which under analysis may melt away and then reveal the hidden psychotic core" (Bychowsky, 1966 : 90).

L. Grinberg (1966) presented two cases of obsessional neurosis. The first showed an admixture of paranoid and schizoid traits, and the second, prominent depersonalisation episodes. In his psychodynamic elucidation of both cases Grinberg appeals to both classical and Kleinian hypotheses on obsessional neurosis (Grinberg, 1966 : 177-78).

D. Freedman (1965) argued in favour of the primacy of oral determinants in obsessional children. This thesis is in sharp contradistinction to the classical formula. Freedman also stressed the relative neglect of the role of early phases of development in the obsessional, excepting from his criticism Melanie Klein, M. Abraham and E. Glover (Freedman, in Gabe, 1965).

It is evident that the above authors all point to an interface between obsessional symptomatology, obsessional organization or obsessional neurosis and disorders which are psychotic in nature. Furthermore, Joseph, Freedman and Grinberg appealed directly to M. Klein's theses on obsessional neurosis so as to develop their own formulations.

Both E. Glover (1935) and M. Klein (1932) appear to argue that obsessional neurosis constitutes an actual defence against psychotic disturbances. Thus Glover writes: "Whereas the obsessional neurosis in adults serves to conceal the fact that, but for its help in instinctual

crises, there would be no stopping for the patient short of the psychoses, the 'obsessional phase' of infancy serves to conceal the fact that but for its activities there would never be any advance for any child out of the 'normal pan-psychosis' of the first year" (Glover, 1935, in Nagera, 1976 : 91).

In a similar vein, M. Klein states: "It seems to me that obsessional neurosis is an attempt to cure the psychotic conditions which underline it, and that in infantile neurosis both obsessional mechanisms and mechanisms belonging to a previous stage of development are already operative" (Klein, 1932 : 226).

As can be gauged from the above excerpts the distinction between obsessional symptomatology, obsessional organization, obsessional mechanisms and obsessional neurosis is not clearly established. A common thread, however, runs through these writings: the need to re-examine obsessional neurosis. This need bears witness to a feeling that the subject is far from being well understood and that the classical formula does not go far enough.

Furthermore, it is apparent that M. Klein's writings on obsessional neurosis enjoy a definite status amongst various authors (Joseph, 1966; Grinberg, 1966; Freedman, 1965), who find in her work support for their own re-exploration of the field. More specifically, it appears that Klein's writings emphasize the early oral phase of development, the psychotic structures established in the first year of life and their etiological role in obsessional neurosis. At this juncture, it can be tentatively argued that important differences between her views and those of the classical formula do exist. However, a systematic exposition of Klein's writings on obsessional neurosis is nowhere to be found in

the psychoanalytic literature (Nagera, 1976). One of the aims of this thesis is to attempt such a comprehensive statement of Klein's writings on obsessional neurosis.

### 1.2.3 The 'culturalist approach' to obsessional neurosis

Under the culturalist heading are subsumed the theses advanced by Sandor Rado (1959), Henry Laughlin (1967), Léo Salzman (1973), Bingham Dai (1957), Paul Adams (1973). Individual differences between the above authors pervade their work on obsessional neuroses. However, as stated earlier, the present review aims at uncovering a similarity of explanatory approaches rather than the intricacies of each individual contribution. A common thread which runs through their writings is the theoretically significant departure from Freud's drive theory. These authors are known as 'non-libido' theorists (Adams, 1973). The locus of etiology is situated rather at the level of pathological interaction between mother and child, dysfunctional family styles and oppressive cultural institutions. In other words, interactional and external environmental determinants are given etiological primacy. This difference will become more apparent as some of the main 'culturalist' theses are reviewed.

#### 1.2.3. (a) Rado's Mother-child battle: omnipotence, autonomy, authority.

Sandor Rado is known for his 'adaptational psychodynamics' (Rado, 1959). Rado's approach makes explicit claims to higher reaches of scientific standards than the "speculative ... superbly indefinite and remote" theories of Freud, who, "frustrated by the unfriendly

reception given to his early work by the criphaaei of medicine in Vienna, retreated to an almost complete scientific isolation from which he never emerged" (Rado, 1959 : 327). Attempts to dismiss Freud's work on the basis of his biographical and personal characteristics, a manoeuvre known as psychologisation, are common (Jones, 1964; Mitchell, 1974). But what does Rado offer in his properly 'scientific' venture to explain obsessional neurosis?

Rado places exclusive emphasis on 'rage' at the expense of libidinal factors in the etiology of obsessional neurosis. Rage is a concomitant of the mother-child interaction during toilet-training: "Irritated by the mother's interference with his bowel clock, the child responds to her entreaties with enraged defiance, to her threats of punishment with fearful obedience ... this indoctrination transforms the child's fear into guilty fear and impresses upon him the reparative procedure of expiatory behaviour" (Rado, 1959 : 330). Thus a motivating system is set up, determined by guilty fear over defiant rage, or obedience over defiance.

Rado further advances a four-step theory in order to explain the transformation of a defiant rage into guilty fear. In other words a vestige of psychodynamic theorising survives, so as to account for that most important Freudian notion of the exaggerated sense of guilt (Freud, 1923(a)). Firstly, elated by the success of his early muscular activities, the infant pictures himself as an omnipotent being". Secondly, the punitive mother forces his 'grand illusion' to recede. Thirdly, "sensing that his believed omnipotence is about to evaporate, the child fancies that he has merely delegated it to his parents: they exercise his magic powers for him". Fourthly, the fear of his own omnipotence delegated to his parents appears within his guilty

fear and leads him to 'retroflex the bulk of his defiant rage'. This 'scientific' etiological recipe for obsessional neurosis leads Rado to assert that the obsessional's "silly excesses in cleanliness, orderliness, regularity and punctuality show that his conscience still operates in the world of the nursery - ruled most often by an obsessive mother" (Rado, 1959 : 331-332). Rado's 'scientific' explanation is reductionistic in the extreme. Its main elements are the 'bad', punitive, real mother as the main pathological protagonist who, through her own obsessional pathology, forces the innocent victim to retroflex his rage magnified through the process of 'delegation'. One can almost sympathise with Skinner for his plea to 'evacuate the empty box':

Rado's viewpoint is not even mentioned by Nagera (1976) but his insistence on defiant rage clearly enjoys a certain currency in American clinical circles (Adams, 1973; Salzman, 1973). Furthermore, since this thesis is not a purely academic exercise and its results will be fed back to the clinical community, it is appropriate to mention that clinicians who pay lip service to psychodynamic theory cherish clearcut formulae such as those of Rado. The view that the obsessional neurotic is basically a subject full of anger or rage and that treatment hinges on the cathartic expression of this particular affect is widespread. It is hoped that this work will expose the erroneous nature of such simplistic conceptions.

### 1.2.3. (b) Laughlin's eclectic approach

Henry Laughlin, an eclectic psychiatrist, investigated the main factors which predispose the child to developing an obsessional disorder (Laughlin, 1967). He drew up the following list of etiological factors:

- (i) Parental insecurity
- (ii) Rejection of the child, with the struggle of the parent at concealment of this through the maintenance of an opposite or different outward facade.
- (iii) Parental overambitiousness for the child's success and maturity.
- (iv) Early over-indulgence succeeded by later stringent and contrasting demands for responsibility and maturity.
- (v) Obsessive traits in the parents.
- (vi) Parental, social and religious condemnations of negative feelings.
- (vii) Rejection of spontaneous demonstration of affection by the child. Curbs on spontaneity of any kind.
- (viii) Familial, social or cultural premium placed on obsessional traits.
- (ix) Primordial infantile rage from whatever source and discharge of rage blocked (Laughlin, 1967).

Like Rado, Laughlin places exclusive emphasis on rage and the defiance-submission conflict in the etiology of obsessional neurosis. In addition to the defective mother-child interaction, he includes such causal factors on the family style, curbs on emotional expression, and broader repressive elements of cultural institutions, such as religion, in the elaboration of obsessional defences.

### 1.2.3. (c) The parental empathy deficit

Both Salzman (1973) and Dai (1957) stress the parental empathy deficit in the relationship to the obsessional child. As a result the child develops a sense of being out of phase with his parents. The

parents make obsessive demands in terms of fulfilling the cultural modes. According to Salzman (1968), the consistent theme in all obsessionals is the presence of anxieties about being in danger because of an incapacity to fulfill the requirements of others and to feel certain of one's acceptance. Hence the child develops a dread of being misunderstood or rejected. Dai similarly stresses the general inability of the parents to read the child, manifested either in an over-constraining socialisation or in an infantilising and over-indulgent relationship, (Dai, 1957). As a result, the child's 'inner longings' are not accepted by others and this sets up a structure of uncertainty and doubt as to whether he can fulfill the expectations of others.

The culturalist approach in psychoanalysis is one of the vicissitudes psychoanalysis suffered when it had to export itself from Europe to an American academic milieu dominated by environmentalist notions (Mannoni, 1974; Fages, 1976). Fundamental psychoanalytic concepts such as the unconscious, and its intrinsic link with the theory of psycho-sexuality; the notion of psychological reality and unconscious phantasy (Freud, 1915(a), 1916-17(a); Isaacs, 1952; Lacan 1973) became attenuated or diluted beyond recognition. Psychologicistic notions such as the need for security, the need for recognition, defiant rage came to replace a theory of the development of the subject which Freud had started to build (Lacan, 1973; Mannoni, 1974).

The culturalist approach to obsessional neurosis reflects this dilution of authentic psychoanalytic theory. The locus of etiology is in the main decentered, or shifted away from the theory of the unconscious and rests almost entirely on environmental, interactional, familial and cultural factors. These factors exert a pathological

influence on the fulfillment of the 'innate' needs of the individual as a result of which obsessional neurosis is constituted. The divide between such approaches and classical or Kleinian theory, is enormous.

Both orthodox theory and Kleinian theory focus instead on intrapsychic processes, on the subject's desires and their vicissitudes and on the structuring effect of unconscious phantasies. Their assumption of a properly psychoanalytic terrain does not de jure entail a negation of the influence of environmental factors on the development of the subject. But they insist on the fact that this development is mediated by the unconscious mind or psychical reality (Mitchell, 1974).

Furthermore, this definition of a properly psychoanalytic terrain of investigation precludes a prejudice in favour of external reality (Freud, 1916(a); Isaacs, 1952). From a metatheoretical perspective, the culturalist approach entails a sociologisation of the psyche and leads to the position of a subject without structure. Their theses lack specificity and fail to point out why pathological external influences should lead to obsessional neurosis instead of hysteria, or psychosis.

Despite the important theoretical cleavage which exists between classical theory and the culturalist approach, it is here contended that the emphasis placed by the latter on interactional, familial and cultural variables can in fact inform a broader theory of obsessional neurosis. It is thoroughly plausible that obsessional parenting, a rigid family style or a moralistic religious or economic ideology may well play an important role in the constitution and maintenance of obsessional disorders. However, more specific links between external influences and the intrapsychic dynamics typical of obsessional neurosis would have to be established so as to provide a genuine articulation.

The aim of the present work is rather to explore the other cleavage which has been outlined in this brief review, that is, the convergences and divergencies which do exist between the classical etiological formula and the Kleinian viewpoint on obsessional neurosis.

### 1.3 AIM AND RATIONALE OF THE STUDY

The present thesis is primarily a theoretical exploration. It has two aims: firstly, to provide a systematic exposition of M. Klein's writings on obsessional neurosis, and, secondly to critically compare and evaluate the Kleinian and classical viewpoints on obsessional neurosis.

The thesis is divided into two parts. Part I consists of an in-depth review of the 'classical etiological formula' (Chapter 3) and an attempted systematisation of Klein's writings on obsessional neurosis (Chapters 4 - 5). This part ends with the theoretical comparisons between the two viewpoints (Chapter 6). The evaluation of the claims made by both theoretical viewpoints is established on theoretical grounds and also on the basis of the psychiatric literature on obsessional neurosis (Chapter 2).

Part II is empirical in nature. Two of the author's patients who show extensive obsessional constellations will be presented. Various aspects of the clinical picture will be used so as to illustrate the theoretical controversies that emerge in the theoretical section.

Even though this thesis is theoretically loaded, the practical relevance of such an exploration for diagnostic and assessment for psychotherapy purposes is one of its prime concerns.

### 1.3.1. Practical considerations

Anna Freud (1966) points out that the spectrum of obsessional configurations extend from mild neurosis to the status of an extremely severe pathology bordering on the schizoid or psychotic proper. Several authors at the Amsterdam Congress pointed out the presence of prominent obsessional symptomatology in borderline patients (Grinberg, Bychowsky, Joseph, 1966). The spectrum of obsessional configurations poses the following problem: how do we clinically assess obsessional symptomatology?

Part of the author's own experience with obsessional patients, in the context of a clinical internship, is worth mentioning. Three patients, with whom the author had varying degrees of close contact, were diagnosed as obsessional neurotics using the strict diagnostic criteria of descriptive psychiatry (I.C.D. 9 : 1978). The diagnosis in each case was agreed upon by a consensus of clinicians.

Case I, a young adult male, had been diagnosed over a 2-year period as an obsessional neurotic. Individual psychotherapy had not helped. A switch to an admixture of behavioural and confrontational techniques aimed at expression of anger, was prescribed. The patient developed a severe manic state, with typical psychotic symptomatology. He was hospitalised and re-diagnosed as suffering primarily from a manic-depressive condition. There was no history of overt manic-depressive signs and symptoms prior to the switch in treatment.

Case II, a young pubertal male, developed an obsessional neurosis so severe and extensive that he had to discontinue school. He could not be contained in an individual psychotherapy setting. His family could

not cope with the severity of his anxiety and the intrusiveness of his rituals. He was hospitalised in a therapeutic community milieu for a protracted 8-month period. His neurosis abated only very slightly. His prognosis is poor and his future development impaired.

Case III, an adolescent male, also diagnosed as obsessional neurotic, managed to resume school after an interruption of one month after onset. He was fruitfully contained in an individual psychotherapy setting. His social adjustment was on the whole intact and his prognosis good.

These three cases illustrate the spectrum of obsessional neurosis and a definite elusive quality which this pathology exhibits. Their widely divergent severities, evolutions, and prognoses point to the imperative need to go beyond the mere inventory of signs and symptoms on which psychiatric diagnosis is based. However useful and essential psychiatric assessment is (Malan, 1979), it is not within the ambit of descriptive psychiatry to pinpoint the 'inner fabric' or the internal structure of the neurosis (Nagera, 1976). For the clinician in general, and for the psychotherapeutically oriented clinician in particular, it is vitally important to be able to pinpoint the various features of this 'inner fabric'. It is on such a basis that the various problems which face the psychotherapist can be answered.

The term psychotherapy here is not used to refer only to the transactions between therapist and patient which make up the therapeutic hour but rather to the total therapeutic act as described by Malan (1979). It involves:

- (a) Assessment of the patient's suitability for psychotherapy.
- (b) Predictions as regards prognosis.

- (c) Predictions as regards how the patient will respond if certain elements of his conflicts are exposed.
- (d) Anticipation of the therapeutic complexities which are likely to ensue.
- (e) Assessment of the possibility of provoking an increased disturbance through treatment.
- (f) Assessment of the clinician's resources and skills to cope with the types of problems presented by the patient.

A basis assumption which underlies the thesis is that psychodynamic theory enables the clinician to assess, evaluate and weigh up the various elements of the internal fabric of the neurosis and, as a result, allows for better diagnostic assessment and treatment recommendation (Malan, 1979; Nagera, 1976). This need for more in-depth evaluation is the more imperative with obsessional patients owing to the spectrum of obsessional pathology and its interface with psychotic disorders.

It is legitimate, in the context of the three cases mentioned above, to ask the following questions. Was Case I suffering from a true obsessional neurosis? Psychiatrically speaking he was, but were there any elements in the internal fabric of his pathology which could have alerted the clinician to the deterioration which ensued? And if there were, is it possible that his obsessional constellation was a defence against a psychotic disturbance? Similarly, how can the difference between Case II and Case III be accounted for given the same descriptive diagnosis? These are the type of questions which the thesis aims at exploring.

### 1.3.2 Theoretical considerations

The classical etiological formula, as the term formula suggests, specifies certain psychodynamic elements which account for obsessional neurosis. In Chapter 3, the elements of the formula are comprehensively reviewed. Special emphasis is placed on the original writings of Freud and the subsequent additions and contributions made by post-Freudians and ego-psychologists who subscribe to the formula.

It will be emphasised that an in-depth understanding of those explanatory hypotheses provides the clinician with a series of tools which enable a more nuanced and precise statement and assessment of the conflicts that permeate the obsessional neurotic's picture. Such an exercise in 'metapsychological assessment' (A. Freud, 1965; Nagera, 1976) will be undertaken in part II in the case of a patient treated by the author.

The classical formula considers obsessional neurosis to be a transference neurosis (Freud, 1926; Fenichel, 1945; Nagera, 1976). Central to the concept of transference neurosis is the notion that the phallic Oedipal structure, with its specific anxieties and conflicts, plays the leading organising role in such neuroses (Freud, 1926; Tolpin, 1970). The reasons why Freud maintained the etiological centrality of the Oedipus Complex in obsessional neurosis will be fully considered in Chapter 3.

However, the concept of transference neurosis with the phallic-Oedipus complex as its central explanatory feature, has a range of application. It is not within its scope to explain the type of conflicts, defence-mechanisms, ego, super-ego and id structures evident in psychotic conditions such as the borderline state or manic-depressive illness

(Tolpin, 1970; Eissler, 1954). In other words, when psychoanalysts characterise obsessional neurosis as a transference neurosis, they do not simply refer to the presence of a certain type of symptomatology but also, and especially, to a psychodynamic fabric in terms of which the symptomatology is intelligible.

Obsessional neurosis as a transference neurosis is assessed on the basis of observable symptoms and on the basis of an endopsychic structure which the classical etiological formula specifies. If obsessional symptoms obtained in a clinical picture dominated by endopsychic elements different to those described by the classical etiological formula, psychoanalysts would reserve judgement as to whether they were dealing with an obsessional neurosis (Nagera, 1976).

It is in this context that the writings of Melanie Klein on obsessional neurosis are theoretically interesting. In the absence of a proper systematic presentation of her work in the literature the following areas of investigation are suggested. The theoretical exploration will elucidate their fruitfulness.

Klein adopts the stance that obsessional neurosis is an attempt to cure the psychotic conditions which underlie it (Klein, 1932). Does Klein use the term 'psychotic' to refer to intrapsychic conflicts as articulated by the paranoid-schizoid and the depressive positions, or to refer to actual psychotic disorders? This issue will be fully investigated in Chapters 4 and 5 in the present work. The investigation also aims at determining the place Klein assigned to obsessional neurosis along the neurosis-psychosis continuum, a concern central to the theory of obsessional neurosis given its spectrum.

Klein has developed her own concept of obsessional mechanisms, which appear during the anal phase and which she claims are at the base of obsessional neurosis (Klein, 1932, 1935, 1940, 1952). Both Grinberg (1966) and Joseph (1966) refer to her concept of obsessional mechanism but do not spell out what they are. In Chapter 5, a systematic exposition of Klein's writings on obsessional mechanism is undertaken.

If Klein places a major emphasis on the etiological role of obsessional mechanism in obsessional neurosis what etiological weight does she assign to the phallic-Oedipal complex, that is, to the central etiological tenet of the classical formula? Similarly, Klein diagnoses children of 2-years old as obsessional neurotics (the cases of Erna and Rita - Klein, 1932). Such early diagnoses indicate that she de-emphasises the role of the phallic-Oedipus complex in the formation of obsessional neurosis. The opinion of other psychoanalysts on obsessional symptoms in very young children, and, the psychiatric studies on the earliest age of onset of the neurosis are reviewed in Chapter 2.

It is hypothesised that there are important contradictions between the classical etiological formula and the Kleinian viewpoint on obsessional neurosis. The main aim of the thesis is to trace the continuities and discontinuities between the two theories.

In Chapter 6, it will be argued that Klein's obsessional mechanisms fail to account for the formation of obsessional neurosis. However, it is also pointed out that Klein has best articulated the notion of an obsessional defence against psychotic disturbances. This argument will be supported by the case study of one of the author's patients who manifests extensive obsessional symptomatology and yet fails to

show the endopsychic structure typical of obsessional neurosis.

In a conclusion to part II it is argued that obsessional symptomatology, because of its spectrum, demands careful assessment which goes beyond the mere description of signs and symptoms. The classical formula best describes an endopsychic structure which leads to typical obsessional neurosis. The Kleinian viewpoint and the theory of obsessional mechanisms best describes an endopsychic structure which is found in psychotic constellations with an admixture of obsessional symptomatology.

A discursive style has been deliberately chosen throughout the thesis: arguments always proceed from first principles and basic concepts are defined as the argument proceeds. This stylistic choice is justified on two grounds. Firstly, psychoanalytic propositions are complex and often elusive. It is thus important to state them with as much clarity and specificity as possible. Secondly, psychoanalytic formulae can be used in an impressionistic manner which attenuates their authenticity and depth. The author attempts at avoiding such a pitfall.

## II

CHAPTER IIPSYCHIATRIC CONSIDERATIONS2.1 Definition

In the International Classification of Diseases (I.C.D. 9, 1978) obsessional neurosis is defined as follows:

"States in which the outstanding symptom is a feeling of subjective compulsion - which must be resisted - to carry out some action, to dwell on an idea, to recall an experience, or to ruminate on an abstract topic. Unwanted thoughts which intrude, the insistency of words or ideas and ruminations or trains of thought, are perceived by the patient to be inappropriate or nonsensical. The obsessional urge or idea is recognised as alien to the personality but as coming from within the self. Obsessional actions may be quasi ritual performances designed to relieve anxiety, e.g., washing the hands to cope with contamination. Attempts to dispel the unwelcome thoughts or urges may lead to a severe inner struggle, with intense anxiety" (I.C.D. 9, 1978 : 36).

The essential features of such a definition are:

- the experience of an inner compelling force, under the form of ideas of urges, which obtrudes insistently into the individual's conscious awareness.
- the attempt to resist the force.
- the retention of insight into the irrationality or senselessness of such phenomena.

These are the three essential criteria upon which the diagnosis of obsessional neurosis is made (Lewis, 1935; Mayer-Gross, Slater and Roth, 1969; Nemiah, 1975).

### 2.1.1 The symptomatology of obsessional neurosis.

Four types of obsessional symptoms are distinguished in official psychiatric taxonomy: obsessions, compulsions, behavioural manifestations and obsessional character-traits (Nemiah, 1975; Mayer-Gross, Slater and Roth, 1969).

- Obsessional thoughts refer to thoughts, words and mental images which obtrude into the individual's conscious awareness. They usually refer to actions which have been performed in the past or which will lead to dreadful consequences (Nemiah, 1975). Disease, dirt, sexuality, causing harm or death, and violence, are typical themes in such thoughts (Sternberg, 1978). A special preoccupation with thoughts is designated by the term "obsessive-ruminative states". The central feature is rumination about an abstract and obtuse topic of a philosophical or religious nature. Pros and cons are considered in a prolonged, fruitless and inconclusive inner dialogue. These abstract preoccupations are fraught with doubt and despair, a feature which has earned the syndrome the French designation of 'folie du doute' (Nemiah, 1975; Sternberg, 1978).
- Compulsions are psychical phenomena also occurring at the level of thinking, but their central feature is an irrational impulse to some form of action. The impulse, although it leads to fear of losing control, remains merely an impulse, and is not acted on by the patient. Typical compulsions are urges to hurt, to defy, to shock, to shout abuse or to blaspheme. The anxiety provoked by such thoughts may lead to avoidance reactions which

superficially are similar to phobias (Mayer-Gross et al, 1969; Nemiah, 1975).

#### Behavioural manifestations

Compulsive acts, unlike obsessions and compulsions, consist of manifest behaviour and are visible to anyone who is there to see them. In general they are attempts to control or modify an obsession or compulsion, whether these refer to past, present or future events. They can be simple acts such as touching, uttering a nonsensical formula, or a gesture, or they can be highly elaborate, repetitive and stereotyped rituals. Common examples are cleaning and bed-time ceremonials, checking rituals, avoidance rituals, e.g. of the colour brown, and meticulous re-arranging of objects (Nemiah, 1975; Stern and Cobb, 1978).

#### Obsessional character traits

Obsessional neurosis does not necessarily arise from the soil of an anankastic pre-morbid personality. But a significant proportion of obsessional neurotics exhibit a combination of anal or anankastic character traits. The most common are: exercise of control over self or others by emphasising rationality, sobriety, emotional distancing, lack of flexibility and extreme caution; cleanliness, orderliness and tidiness, and favouring of a predictable environment; miserliness about possessions, and excessive frugality, and stubbornness of purpose often accompanied by compliance and over-conscientiousness (Mayer-Gross et al, 1969).

## 2.2 Epidemiology

Natural history studies have found an incidence of obsessional neurosis that is never higher than 5% of the total psychoneurotic population (Lewis, 1936; Kringlen, 1965; Nemiah, 1975). However, those studies conducted on hospital in-patients are inaccurate since it is generally accepted that obsessional neurotics are secretive about their symptoms and avoid disclosing them to physicians. It is possible that the 5% figure is lower than the actual incidence in the population at large.

There appear to be no significant sexual differences in the incidence of the disorder and an equal percentage of men and women are affected (Nemiah, 1975; Sternberg, 1978). A large proportion of obsessional neurotics remain unmarried, up to 50% in some surveys (Kringlen, 1965). The frequency of the disorder is higher in middle class individuals and in those with higher intelligence levels (Nemiah, 1975).

## 2.3 Onset, course and prognosis

Accurate information about the course and prognosis of obsessional neurosis is precluded by the dearth of adequate natural history studies on the syndrome (Kringlen, 1965; Nemiah, 1975).

### 2.3.1 Onset

Owing to the theoretical relevance of the age of onset of obsessional neurosis, a comprehensive review of existing studies on the said topic will be undertaken.

Studies on adult patients (Kringlen, 1965; Beech, 1974; Nemiah, 1975; Sternberg, 1978) indicate that the onset of the disorder occurs predominantly in adolescence or early adulthood. The symptoms first appear in over 66% of patients by the time they are 25. In only less than 5% of patients do the symptoms begin for the first time after the fourth decade of life. According to Sternberg (1978) one third of the patients have precursory symptoms in childhood, without precise description of the age in childhood. According to Nemiah (1975), 10 to 15% of adult patients experience obsessional symptoms before the age of 10. Beech (1974) states that 33% of adult obsessional neurotics have an onset before age 15. Kringlen (1965), without age specification states that 20% have childhood symptoms.

Some researchers have addressed themselves more particularly to the issue of the earliest age of onset but, on the whole, information is scanty. Bermann (1942), using strict diagnostic criteria, diagnosed 6 obsessional neurotic children out of a sample of 3 050: the mean age of onset was  $11\frac{1}{2}$  years, range 10 to 12 years. Judd (1965) also using rigorous diagnostic procedures, studied 5 cases and found the average age of onset to be  $7\frac{1}{2}$  years, range  $6\frac{4}{12}$  to  $10\frac{2}{12}$ . Adams (1973) with a sample of 49 'obsessive children' reports an average age of onset of 5.8 years, range 1 to 14 years. Rapoport et al (1981), using strict selective criteria, found an average age of onset of 9.5 years, range  $\pm 4.1$  years.

On the whole, existing research tends to show that the obsessional neuroses of childhood usually occur between the ages of 5 and 10. Adams' study is the only exception, and according to him 12 of his patients developed obsessional symptoms or neurosis before the age of 5 (Adams, 1973 : 207). His information was obtained from

parental reports and not from direct observation, and his diagnostic procedure has been criticised for its lack of rigour, and for not distinguishing between state and trait (Rapoport et al, 1981 : 1545).

There is no rigorous study on obsessional neurosis and obsessional symptoms in the pre-school child. Developmental psychologists (Piaget, 1954; Gesell, 1940) have described ritualisation of behaviour in children of two and three years of age. The compulsive quality of their play activity has also been stressed. However, both Piaget and Gesell do not see such 'obsessional' behaviours as neurotic, and regard them as inherent in normal development and important from a cognitive point of view. Anna Freud, and the Hampstead team, consider such behaviour to be phase adequate behaviour, and stress that it is not to be confused with obsessional neurotic behaviour (A. Freud, 1965; Sandler and Joffe, 1965). Anna Freud draws attention to the significance of strong obsessional manifestation in very young children as possible indicators of "splits and disharmonies within the structure, severe enough to lead later to a psychotic total disintegration of the personality" (A. Freud, 1965 : 153). Thus the existence of obsessional manifestations in very young children are not seen as neurotic but rather as normal, on the one hand, or, if they are excessive, as attempts by the child's ego to deal with psychotic or borderline types of disturbances (Sandler and Joffe, 1965).

### 2.3.2 Course and prognosis

The better studies which include personal examination by the authors, and a relatively long follow-up period (Balslev-Oleson et al, 1958; Kringlen, 1965) suggest that long-term prognosis is not as pessimistic as previously thought (Nemiah, 1975): 15 to 20% are much

much improved; approximately 30 to 40% are improved, and 40 to 45% are unchanged. Kringlen reports that 7% of his sample became psychotic although none of those patients were typical obsessionals to start with, and the symptomatology might have led one to suspect a psychotic development at an early stage. Goodwin et al (1969) in a review of the literature conclude that obsessional neurosis does not involve an increased risk of suicide, antisocial behaviour or the development of another mental disorder such as schizophrenia.

In general, obsessional neurosis is a chronic disorder. The following factors favour a better prognosis: a short duration of symptoms prior to the time the patient is first seen; a high element of environmental stress associated with the onset of the disorder; and good general social adjustment and relationships (Nemiah, 1975).

## 2.4 Differential diagnosis

### 2.4.1 Organic states

Obsessional type of behaviour can occur in association with temporal lobe lesions and certain kinds of encephalitis (Nemiah, 1975). These phenomena however, are more motoric than mental in nature, and hence are not strictly speaking obsessional.

### 2.4.2 Phobic neuroses

It is often difficult to distinguish sharply between obsessional neurosis and phobias. If, in a certain proportion of cases, it is easy to show that the avoidance of a phobic object emerges from within an obsessional matrix, e.g., the fear of an elevator due to the fear of an obsessional impulse to push people down the shaft, in many cases

it is difficult to establish such clear-cut distinctions (Nemiah, 1975).

Salzman (1973) has provided the most elaborate classification of the admixture of phobias and obsessional neurosis. He distinguishes between four types:

- Obsessional neuroses without phobic symptoms.
- Obsessional neuroses with mild phobic symptoms: the avoidance rituals usually relate to the context of the obsessions or compulsions, e.g., the avoidance of knives because the obsessional ideations concern murder.
- Obsessional neuroses with moderate phobic symptoms: such patients usually present with phobias and it is easy to miss the underlying obsessional state, and the person may be unaware of his obsessional problems.
- Obsessional neuroses with severe phobic symptoms: in this category the underlying obsessive-compulsive patterns are frequently either in the background, or completely hidden, and the phobias appear to be the sole problem that requires treatment. (Cov

Salzman goes beyond the empirical relation, and hypothesises the dynamic role of phobias as an absolute means of modifying anxiety in the advent of a failure to do so by obsessional means (Salzman, 1973).

#### 2.4.3 Depression

There are areas of overlap between obsessional neurosis and the syndrome of depression. Some 20% of patients with manic-depressive illness have obsessive-compulsive symptoms and 33% have obsessive-

compulsive traits (Mayer-Gross et al, 1969; Nemiah, 1975). However, the literature does not specify the exact relationship between obsessional neurosis and depressive illness. Nor does it specify whether obsessional neurosis can deteriorate into manic-depressive psychosis.

Nemiah (1975) asserts that pure depressive and pure obsessional neurotic patients represent two ends of a spectrum. Those cases who fall in between show many features in common. Rosenberg (1968), investigating the complications of obsessional neurosis, found that severe depression is a common complication in severe cases of obsessional neurosis: 30% of his sample were treated with drugs or E.C.T. for moderate to severe depression. However, the risk of suicide, alcoholism, or drug addiction is insignificant amongst obsessional neurotics (Rosenberg, 1968; Goodwin et al, 1969; Kringlen, 1965).

#### 2.4.4 Schizophrenia

Obsessional symptomatology has been observed in schizophrenics. Rosen, in a most comprehensive study, states that only 3.5% of the total schizophrenic population presented with obsessional symptoms. Most of those were paranoid schizophrenics (Rosen, 1954). Rosen's study (1954) confirmed Stengel (1945) hypothesis that obsessional symptoms play the role of preventing or retarding disintegration in adult schizophrenics (Stengel, 1945).

The area of contact between the two syndromes has been investigated more thoroughly, and results tend to show that the relationship between schizophrenia and obsessional neurosis is tenuous (Nemiah, 1975). The studies done on obsessional neurotics show that only

1% (Pollitt, 1957) to 12% (Muller, 1953) develop schizophrenia, and the range seems to be related, in part, to the strictness with which the initial obsessional illness was diagnosed by the investigator. Thus Kringlen (1965) found that 6.5% of his sample developed psychosis or borderline psychosis, but adds that none of those who did were typical obsessives. Goodwin et al (1969) assert that if schizophrenia is clearly ruled out at the beginning, obsessives do not become schizophrenic more often than non-obsessives. Rosenberg (1967) found that 2.8% of his obsessional sample became schizophrenic, but points out that the diagnosis was suspect, because those obsessives showed a schizoid premorbid personality.

The above studies tend to show that a small proportion of schizophrenics show obsessional symptomatology. Conversely, a small proportion of obsessional neurotics develop schizophrenia or borderline disorders. The diagnostic difficulties arising in such cases points in the direction of an interface between obsessional neurosis and schizophrenic or schizoid types of disorders.

#### 2.4.5 The obsessional personality

Although many obsessional neurotics exhibit obsessional character traits, there are grounds to make a distinction between the obsessional personality, and the neurosis. Nemiah (1975) asserts that in 30% of obsessional neurotics there is no prior history of obsessional character traits. Sternberg makes the point that only some people who have an obsessional personality suffer or become ill (Sternberg, 1978). Kringlen (1965) found that 28% of his large sample of obsessional neurotics did not have prior obsessional traits. Thus a significant proportion of obsessional neurotics do not feature an anankastic

personality disorder, and many individuals with an obsessional personality do not become obsessional neurotics.

It is thus important to make a distinction between the label obsessional neurotic and the label 'obsessional' used in a loose way so as to refer to an obsessional style or an obsessional cluster of traits.

CHAPTER 3THE CLASSICAL ETIOLOGICAL FORMULA  
OF OBSESSIONAL NEUROSIS

The most important tenets of the classical viewpoint were formulated by Freud. In this chapter the originality, depth and extensiveness of Freud's writings on the topic are fully investigated. The author has chosen to rely on the original Freudian texts instead of secondary sources. Contributions by other authors - post-Freudian and ego-psychologists - are included where relevant. X

Since clinical aims - assessment and psychotherapeutic - equally underlie this thesis, certain aspects of Freud's work which are relevant to clinical practice with obsessional patients are explored, although they are peripheral to the central theme of the present work. For example, Freud's studies on the phenomenology of obsessional symptomatology are still pertinent today because they give the clinician an insight into the complex maze obsessional symptomatology presents, whereas more empirically based taxonomies do not. Furthermore, the semantic richness of symptoms, a central concern of an authentic psychoanalytic approach, is emphasised.

On discussing aspects of the anal-sadistic organization, or of the phallic-Oedipus Complex, the author has chosen to elaborate on the position of such concepts within the broader theory of psycho-sexuality. Particular care is taken to show that such notions relate to major psychical structurations which mark the development of the human subject hence their clinical relevance and importance. If such notions are not understood on the proper terrain of unconscious psychical reality, they become non-sensical formulations which are easily derided and whose import is missed. O

Finally, the classical viewpoint is not a neat or unproblematic package deal. It has its own internal contradictions and weaknesses. Some of these are taken up and fully explored.

### 3.1 The Phenomenology of Obsessional Neurosis.

#### 3.1.1 Neurotic symptoms and language.

Symptom formation is a special field of study in psychoanalysis.

× A symptom is a compromise formation between repressed unconscious wishes and the ego defences (Freud, 1916[c]). It would be a half-truth to say that the symptom points to underlying conflicts: it is a codified expression of psychical conflicts and thereby constitutes a means through which the unconscious 'speaks'. The point made here is that the symptom is a product of what linguists call the signifying function (Lemaire, 1976; Piaget, 1973) by virtue of which it has meaning. Freud's anticipatory insights into the link between the unconscious and language have recently been re-emphasised and re-valued by Lacan's school of psychoanalysis (Lacan, 1966; Forrester, 1980). Although this thesis cannot be fully developed here, it is important to stress the above rapprochement as it will shed light on Freud's particular approach to the phenomenology of obsessional neurosis.

The symptoms of obsessional neurosis differ from those of conversion hysteria in one major respect. In hysteria the body becomes the dominant site of signification. The essence of hysterical conversions is aptly captured by Ferenczi's formula: "the hysterical materialisation of unconscious phantasies" (Fenichel, 1946). The soma and the body become the cumbersome representative of unconscious wishes and conflicts.

In obsessional neurosis a significant proportion of the symptomatology

occurs at the level of thinking (Freud, 1909; A. Freud, 1966), in other words at the level of language. The cumbersomeness of iconic representation (as in the dream), or of somatic and bodily representation, (as in hysteria) is thereby averted, since in obsessional neurosis the symptom is thoughts, that is, linguistic signs. It is therefore understandable why Freud pinned so many hopes on the relevance of the psychoanalytic study of obsessional neurosis for the more general theory of the unconscious: "I shall not in the present paper attempt any discussion of the psychological significance of obsessional thinking. Such a discussion would be of extraordinary value in its results, and would do more to clarify our ideas upon the nature of the conscious and the unconscious than any study of hysteria or the phenomena of hypnosis" (Freud, 1909 : 228).

### 3.1.2 Obsessional symptoms and the 'two-step' theory of defence

Freud maintained his early distinction between three types of obsessional symptoms: obsessional ideas, obsessional affects, and obsessional protective measures or acts (Freud, 1896, 1915(c), 1926). Freud's taxonomy of obsessional symptomatology differs from the official psychiatric taxonomy (I.C.D. 9, 1978) in significant ways. A comparison is fruitful since it brings into relief the underlying conceptual framework upon which the taxonomy is ultimately founded.

Freud's taxonomy cannot be considered in isolation from the particular theory of defence which pervades both his pre-psychoanalytic writings and his more mature work. Three of his writings which span the thirty years of his work, and which address themselves directly to obsessional symptomatology (Freud, 1896, 1915(c), 1926) show a remarkable continuity as regards the 'two-step' theory of defensive

conflict. Despite the radical transformations which occurred over those thirty years which directly affected the theory of obsessional neurosis (refer to 3.2.2), the distinction he established in his Further Remarks on the Neuro-Psychoses of Defence (Freud, 1896) between primary and secondary defence, is reiterated in his metapsychological paper "On Repression" (Freud, 1915(c) ) and is still valid in his definitive "Inhibitions, Symptoms and Anxiety" (Freud, 1926).

In a nutshell, the failure in primary defence, that is, the failure of repression (Freud, 1915(c) ) leads to the formation of primary symptoms, or derivatives of the unconscious, which make their way to consciousness. The ego puts up a secondary defensive struggle against those derivatives of the unconscious. Obsessional symptoms in the Freudian taxonomy are categorised on the basis of whether they are primary symptoms, that is, compromise formations resulting from the primary defensive conflict, or whether they are part of secondary defence against the primary symptoms (Freud, 1896, 1909, 1926).

Furthermore, a complex intrusion of the primary symptoms into the secondary defensive shield is particularly evident in obsessional neurosis. Freud's taxonomy of obsessional symptoms is based on this particular theory of defence.

Obsessional ideas and obsessional affects, are the direct derivatives of the unconscious, that is, the return of the repressed after failure in the primary defence. Of obsessional ideas Freud writes: "In point of fact it would be more correct to speak of 'obsessive thinking', and to make it clear that obsessional structures can correspond to every kind of psychical act. They can be classed as wishes, temptations, impulses, reflections, doubts, commands, or prohibitions" (Freud, 1909 : 222). Whereas official psychiatric taxonomies

(I.C.D. 9, 1978; Freedman, et al, 1976) establish a distinction between obsessions and compulsions on the basis that the latter are irrational impulses to some form of action (Nemiah, 1975) whilst the former have no relation to action, Freud by-passes such a distinction. His category of obsessional ideas comprise both obsessions and compulsions. They are primary symptoms or distorted representatives of the unconscious.

Obsessional affects are dominated by self-reproach or guilt (Freud, 1896). However, self-reproach can achieve a variety of forms which appear in consciousness: "When this has happened there is no longer anything to prevent the substituted affect from becoming conscious" (Freud, 1896 : 171). Thus the more primary guilt can manifest as:

- (a) shame
- (b) hypochondriacal anxiety (fear of physical injuries).
- (c) social anxiety (fear of being punished by society).
- (d) religious anxiety.
- (e) fear of temptation (mistrust of one's moral power of resistance).
- (f) fear of being noticed.

(Freud, 1896).

Psychiatric taxonomy does not consider obsessional affects as a separate type of obsessional symptom. It usually includes feelings of 'anxious dread' or 'anxiety' as an intrinsic part of the clinical picture (I.C.D. 9, 1978). Furthermore, the various forms under which anxiety can manifest are not distinguished. The distinctions elaborated by Freud are important from a differential diagnostic point of view.

As an example a patient was referred to the author with the diagnosis

of anxiety neurosis: he spoke mostly of the fears of his own death. Rigorous prompting elicited his obsessional fear of the death of others, a myriad of obsessional thought patterns, checking rituals and other elements of a typical obsessional neurosis.

The third type of obsessional symptom in the Freudian taxonomy is called protective measures or obsessional actions (Freud, 1896). They are an intrinsic part of the secondary defensive struggle initiated by the ego against obsessional ideas and obsessional affects: "For the ego seeks to fend off the derivatives of the initially repressed memory, and in this defensive struggle it creates symptoms which might be classed together as 'secondary defence'. These are all of them 'protective measures' which have already done good service in the fight against obsessional ideas and obsessional affects" (Freud, 1896 : 172). Protective measures, or obsessional actions, are not equivalent to the category of behavioural manifestations in psychiatric taxonomy (Nemiah, 1975). Some protective measures take place purely at the level of the thought-process, whilst others take place at the level of manifest behaviour. In the category of obsessional actions Freud includes

- (a) Obsessional brooding or ruminations: "Secondary defence against obsessional ideas may be effected by a forcible diversion on to other thoughts with a content as contrary as possible. This is why obsessional brooding, if it succeeds, regularly deals with abstract and suprasensual things: because ideas that have been repressed are always concerned with sensuality" (Freud, 1896 : 173).
- (b) Compulsion to test things.
- (c) doubting mania.

- (d) penitential measures (burdensome ceremonials, observation of numbers).
- (e) precautionary measures (all sorts of phobias, superstitions, pedantry, and an increase in the primary symptom of conscientiousness)
- (f) measures to do with fear of betrayal.
- (g) measures which ensure numbing of the mind (dypsomania)

(Freud, 1896 : 173).

The secondary defence often fails and "in time the thing which is meant to be warded off invariably finds its way into the very means which is being used for warding it off" (Freud, 1909 : 225). This is an observation which Freud had already made in 1896, and is thoroughly confirmed throughout his writings on obsessional neurosis. Thus in 1896 Freud writes: "There are cases in which one can observe how the obsession is transferred from the idea or the affect in to the protective measure; others in which the obsession oscillates periodically between the symptom of the return of the repressed and the symptom of the secondary defence" (Freud, 1896 : 173). In Totem and Taboo he pursues the same idea: "It is possible, however, to describe the course of development of obsessive acts: we can show how they begin by being as remote as possible from anything sexual - magical defences against evil wishes - and how they end by being substitutes for the forbidden sexual act and the closest imitation of it" (Freud, 1912 : 83). In Inhibitions, Symptoms and Anxiety, Freud elaborates in a similar vein: "The symptom-formation scores a triumph if it succeeds in combining the prohibitions with satisfaction so that what was originally a defensive command or prohibition acquires the significance of a satisfaction as

well; and in order to achieve this end it will often make use of the most ingenious associative paths. Such an achievement demonstrates this tendency of the ego to synthesize, which we have already observed" (Freud, 1926 : 26).

In his Rat-Man case (Freud, 1909), Freud gives a spectacular demonstration of such a 'triumph' of the unconscious over the secondary defence. It is worthwhile reproducing this example as it illustrates the thoroughness of his investigation into the phenomenology of obsessions and the intrinsic link between symptom formation and what Lacan has called "the effects of language" (Lacan, 1966 : 281). Glejisamen was a particular protective formula which the Rat-Man uttered so as to chase away certain obsessional ideations and the concomitant dread. This particular symptom developed in the context of his onanistic practices. This magical anagram was a collation of meaningful letters or phonemes from short prayers to which a final 'amen' had been added. Careful linguistic analysis revealed the following meaning:

G	(	GL	=	(gluckliche)	=	to make happy
L	(	L	=	all of them		
E	(	E	=	forgotten		
J	(	J	=	(jetz und immer)	=	now and ever
I	(	S	=	forgotten		
S	(	AMEN	=	so be it		
A	(					
M	(					
E	(					
N	(					

As a secondary symptom this magical formula had an eminently religious meaning for the Rat-Man. However, Freud shows (Freud, 1974) that this formula is equally a pregnant metaphor, a codified expression of the unconscious derivatives it attempts to ward off, although this

particular signification totally escaped the conscious rationalisations of the subject. It is as if the unconscious, through the metaphoric potentiality of language, completely subverts the conscious subject and, thereby, the primary symptoms infiltrate the very secondary defence erected against them. Thus Glejisamen is equally a distorted representative of:

Gisela = one of the two women the Rat-Man was involved with and who aroused his deeply rooted ambivalence. Her real name was Gisela Fluss.

Samen = semen = masturbation = dirt in anal-erotic language.

The masturbatory phantasies (evil thoughts) were unwittingly fulfilled in the very sacred anagram constructed to ward them off.

Freud was dissatisfied with the knowledge about obsessional symptomatology: "It must be confessed, however, that even the phenomenology of obsessional thinking has not yet had sufficient attention paid to it" (Freud, 1909 : 222). Apart from the distinction between primary and secondary symptoms, and their interpenetration, Freud's perhaps unrivalled flair for meticulous psychoanalytic enquiry led him to establish another type of obsessional formation which he named "deliria" (Freud, 1909). 'Deliria' are, as it were, hybrid thought patterns between obsessional ideas proper, and rational thought engaged in the secondary defensive conflict: "they accept certain of the premises of the obsession they are combating, and then, while using the weapons of reason, are established on the basis of pathological thought" (Freud, 1909 : 222). The Rat-Man was preparing for a law examination late into the night, and he would open the door of his flat

as if to let his dead father's ghost in. He then would take out his penis and look at it in a mirror. This obsessional action expressed both his compliance with his father and the symbolic defiance of him through masturbation. He tried to fend off the disturbing obsession by rationally asking himself what his father would think if he was still alive. But rational arguments had no effect and "the spectre wasn't laid until he had transformed the same idea into a 'delirious' threat, to the effect that if he ever went through this nonsense again some evil would befall his father in the next world" (Freud, 1909 : 223).

### 3.1.3 Psychoanalytic and psychiatric taxonomies

Three main differences have been outlined between the Freudian and the psychiatric taxonomies. To recapitulate, Freud does not stress the distinction between obsessions and compulsions. Furthermore, he lists a variety of obsessional affects of symptoms in their own right. Lastly, his category of obsessional acts includes both covert thought patterns and manifest behaviour. It has been shown that this classification is informed by a particular theory of defence and by a theory of the unconscious. summary

It is suggested here that this difference is at least partly explainable in terms of the fact that psychoanalytic theory, on one level, does not adhere to the mind/body or thought/action dichotomy. From the standpoint of the theory of the unconscious and its close link with the signifying function, thoughts, behaviour, actions and the some are all vehicles of signification, albeit with their own suitability for signification. They all constitute modes of representation of unconscious phantasies and conflicts. As a consequence, symptom

classification is informed by other theoretical considerations, and in particular by the theory of primary and secondary defence.

### 3.2 The Change from Early Trauma Theory

In his pre-psychoanalytic period Freud adhered to the trauma-theory of both hysteria and obsessional neurosis (Nagera, 1976; Wolheim, 1971; Mannoni, 1972; Freud, 1895, 1896). In brief the trauma theory posits that hysterics suffer from the memories of sexual traumata, of a seductive type, passively experienced during childhood. The path to neurosis however is not simple: the real childhood experience of seduction is not traumatic at the time. At the time of puberty and its concomitant sexual efflorescence, an experience re-activates the buried childhood memory, and it is only then that the memory becomes pathogenic and the defensive conflict is set in motion. Thus, the causal efficacy of childhood experience is complex. This complexity is articulated in the theory of deferred action (Freud, 1895; Laplanche and Pontalis, 1973).

Although revolutionary at the time, as it adumbrated the role of childhood and of sexuality in the etiology of the neurosis, the trauma theory of hysteria simultaneously omitted the radically innovative concept of infantile sexuality, since seduction is primarily a passive experience inflicted on the child by an adult. This omission was thus tantamount to a collusion with the official ideology of the 'sexual innocence of childhood', current at the time (Wolheim, 1971; Mitchell, 1974; Mannoni, 1972).

Freud's early etiological formula of obsessional neurosis was slightly different (Freud, 1896). The pathogenic memory in this case

refers to the child's sexual activity: "Sexual experiences of early childhood have the same significance in the aetiology of obsessional neurosis as they have in hysteria. Here, however, it is no longer a question of sexual passivity, but of acts of aggression carried out with pleasure, and of unpleasurable participation in sexual acts - that is to say, of sexual activity" (Freud, 1896 : 168). It would appear, therefore, that Freud's recognition of early childhood sexual activity contradicts the view put forward in the above paragraph as regards the preserved 'sexual innocence' of childhood.

However, Freud himself strongly nuanced this notion of early sexual activity by asserting that: "In all my cases of obsessional neurosis, moreover, I have found a substratum of hysterical symptoms which could be traced back to a scene of sexual passivity that preceded the pleasurable action. I suspect that this coincidence is no fortuitous one, and that precocious sexual aggressivity always implies a previous experience of being seduced" (Freud, 1896 : 169). Despite this insightful early view on the aggressive component of sexuality in obsessional neurosis the early sexual activity of the obsessional neurotic is, in the last instance, conceived of as a sort of mimicry whereby the child does to others what was first done to it (Wollheim, 1971). In the main the 'sexual innocence of childhood' is maintained in this early theory of obsessional neurosis.

Freud's feverish intellectual activity during the years 1895 - 1900, the years of transitions and the dawn of psychoanalysis proper, is well documented (E. Jones, 1964). As the concept of unconscious phantasy came to the fore, the trauma theory was gradually made redundant, since neurotics do not suffer from memories of real childhood events but rather from childhood sexual desires and phantasy-fulfillment of

such desires. This theoretical upheaval led to the publication of two major books: "The Interpretation of Dreams": the book of unconscious desire, and "Three Essays on Sexuality": the book of the drive (Mannoni, 1972). Those were the cornerstones on which all latter theory were based.

As from then onwards the clinical explanation of obsessional neurosis is no simple matter, as Freud's etiological formula grew to combine several causative factors. The most important are namely: ( the Oedipus complex, } the fixation and regression to the anal-sadistic libidinal organization, } the tentative hypothesis of precocious ego-development and } the ego and super-ego reaction to drive regression. In 1926, Freud wrote: "Obsessional neurosis is unquestionably the most interesting and repaying subject of analytic research. But as a problem it has not yet been mastered" (Freud, 1926 : 27 ). Nagera's bilan, fifty years later (Nagera, 1976), as regards the paucity of post-Freudian contributions, is a testimony to the thoroughness of Freud's early insights.

### 3.3 Obsessional Neurosis and the Anal-Sadistic Libidinal Organization

The study of obsessional neurosis led Freud to the discovery of the anal-sadistic libidinal organization. Drawing support from Jones, emphasis on the constant association of traits or impulses to cruelty and of anal eroticism in obsessional neurosis, Freud wrote: "And now we see the need for yet another stage to be inserted before the final shape is reached - a stage in which the component instincts have already come together from the choice of an object and that is already something extraneous in contrast to the subject's own self, but in which the primacy

of the genital zones has not yet been established. On the contrary, the component instincts which dominate this pregenital organization of sexual life are the anal erotic and sadistic ones" (Freud, 1913 :

X 321). The anal sadistic orientation of the obsessional neurotic is identifiable in the clinical picture: conflicts between aggressiveness and submissiveness, cruelty and gentleness, dirtiness and cleanliness, disorder and order are usually evident. Mixtures of reaction formation and direct anal or sadistic urges often give the clinical picture its contradictory character (Fenichel, 1946).

What is the anal-sadistic libidinal organization? What is the link between anal erotism and anal sadism in Freudian theory? In order to answer those two questions, it is important to make a detour into the Freudian concept of sexuality so as to avoid the popular misconceptions and mystifications which surround this topic.

### 3.3.1 The sexual drive and the bodily source

Any libidinal organization is characterised by the primacy of an erotogenic zone, and by a specific mode of object relationship (Laplanche and Pontalis, 1973). On the one hand, the concept of a zone or of the source of the drive (Freud, 1915(b) ) is a direct reference to the somatic or the bodily. On the other hand, the concept of a mode of object relationship refers directly to the psychological. The very definition of a sexual organization contains elements which ipso facto prevent a reduction to the biological or the bodily. It would thus be misguided to regard a libidinal organization "as though a biological scheme existed which would secrete sexuality from certain predetermined zones", exactly as certain physiological setups give rise

to the need for nourishment through certain local tensions" (Laplanche, 1976 : 21). The second term of the definition, the mode of object-relationship, refers to a specific reality which Freud has termed unconscious or psychical reality (Freud, 1915(a), 1916-1917(a) ] and which is dominated by unconscious phantasies. Thus an object relationship comprises three elements: the subject, the object (or the part subject and part-object as in Klein's work), and the position taken by the subject vis-a-vis the object in phantasy. Psychoanalysis has amply shown that the relationship to the real object (the person) is coloured by the phantasmatic relationship with the internalised, psychical, object. The problem is thus shifted onto what exactly is the role of the bodily or somatic referent in the Freudian conception of human sexuality.

The erotogenic zone - the source of the drive and the bodily zones of excitation - constitute a field of study which Freud was content to leave to other scientific endeavours: "The study of the source of instincts lies outside the scope of psychology. Although instincts are wholly determined by their origin in a somatic source, in mental life we know them only by their aims. An exact knowledge of the source of instinct is not invariably necessary for purposes of psychological investigation; sometimes its source may be inferred from its aim" (Freud, 1915(b) : 123). The point cannot be made more succinctly: the bodily or the somatic source of the drive, is an inferred minimum condition, on the basis of the psychoanalytic investigation of unconscious psychical representatives. This characteristic of being a minimum condition is corroborated by the fact that Freud himself (Freud, 1905) considerably extended the range of bodily 'sources' so as to include a whole range of human activities which can

be erotogenic: motoric activity of the whole body, intellectual work and certain affective states.

It is tempting at this stage to draw a parallel with Kantian philosophy so as to illustrate the Freudian position. Insofar as the body, or the 'vital order' (Laplanche, 1976) is referred to by Freud as a source of sexuality, it is done so via the study of its psychical representation. It is inferred as a minimum condition, and its study is delegated to other scientific endeavours: the psychoanalytic discourse is imprecise about the somatic source of the drive, the vital order or the 'instinct'.

If the Freudian concept of the sexual drive rests on a somatic or biological source, the human sexual drive separates itself from the biological in that it is a process which mimics, displaces and denatures it. Laplanche, in his most enlightening "Life and Death in Psychoanalysis" marks the specificity of the Freudian concept of the sexual drive: "Sexuality in its entirety, in the human infant, lies in a movement which deflects the instinct, metaphorises its aim, displaces and internalises its object, and concentrates its source on what is ultimately a minimal zone, the erotogenic zone" (Laplanche, 1976 : 23). The concepts of metaphor and mimicry are important, incorporation, as an aim of the oral drive, mimics the biological function of ingestion of food. As a metaphor it covers a great variety of psychical processes which characterise the oral object-relationship such as: the obtaining of pleasure by making an object penetrate oneself; the cannibalistic incorporation and destruction of the object and its affective consequences; and the keeping within oneself of the object so as to appropriate its qualities, identification or introjection. As a consequence of the role played by the body in

the Freudian concept of sexuality - that of an essential but minimal condition - it cannot be expected that psychoanalytic utterances about the body be clearly specified. They are allusions derived from the psychical metaphor.

## 3.3.2

The anal-sadistic organization

The anal-sadistic libidinal organization is characterised by the primacy of the anal erotogenic zone and an object-relationship which is invested with meanings having to do with the function of defaecation (expulsion/retention) and with the symbolic value of the faeces (Laplanche and Pontalis, 1973). According to Freud (Freud, 1905, 1913) the anal-sadistic organization has two bodily sources. Anal erotism is linked to the pleasure associated with defaecation and the enjoyment derived from the anal products themselves. Sadism on the other hand has as its bodily source the musculature which Freud links with the component instinct for mastery and control (Freud, 1905):

Freud was particularly hesitant about the sadistic component instinct and how it comes to be associated with sexuality (Freud, 1905 : 89). It is classified as a non-sexual instinct which only fuses with sexuality secondarily, and its aim is to dominate the object by force. From a development perspective there is evidence that the neuro-muscular maturation of the child leads to increased activity during the anal stage. An increase in physical aggressivity, noisiness and brutality is equally observed (Dolto, 1971). The pleasure in learning, doing, and mastering which can equally become linked with sadism has been studied (Hendrick, 1943). However, on the whole, exactness about the bodily source of the drive does not obtain. At the level of the

psychical metaphor, anal-sadism is observed in a variety of contexts and has a variety of meanings.

### 3.3.3 The anal or anankastic personality traits

Obstinacy, orderliness and parsimony <sup>NB!!!</sup> (Freud, 1908) are set up as an intrinsic part of the ego, as a result of two psychical processes. Sublimation, on the one hand, is a process whereby the drive becomes directed towards a new non-sexual aim, and usually into activities which are socially valued (Freud, 1915(b); Laplanche and Pontalis, 1973). Reaction formation, on the other hand, is a type of defence mechanism which results in attitudes diametrically opposed to a repressed wish and constituted as a reaction against it (Freud, 1905; 1915(c) ).

Only the briefest reference will be made to the anal-sadistic traits. The literature on such traits is extensive (Jones, 1913; Freud, 1908; Reich, 1928; Brown, 1968 ). Obstinacy or stubbornness is seen by Freudians as a sublimation of the retaining of control over pleasurable anal activities. The obstinate person often shows incredible persistence in the face of insuperable difficulties and contradictory demands. Control over 'doing their own thing' is accompanied by great reluctance at any external interference. It often betrays an aggressive element tied up with an exalted sense of self, an underlying belief in narcissistic omnipotence. As a result, stubbornness is often thinly veiled by its reaction-formation: docility and submissiveness.

Cleanliness is more clearly a reaction-formation against pleasure taken in the product of defaecation. In the child's development,

excretory products only become repelling as a result of this reaction formation: young children have a fascination for their bodily products. They play with them and smearing can be an affectionate gift of something felt to be a private possession (Dolto, 1971; Jones, 1913; Ferenczi, 1913). Washing compulsions and avoidance of dirt is prominent in obsessional symptomatology. But, dirt, which at base can be understood as 'matter in the wrong place', acquires a range of signification implicit in the attitude of orderliness and pedantry. This obsessional trait covers meticulousness, passion for detail, exactitude, punctiliousness, dislike for muddled thinking and a passion for thoroughness and efficiency (Jones, 1913).

Parsimony in its extreme form becomes miserliness. It is a metaphor for both the pleasure taken in retention, and the narcissistic over-valuation of the product. There are two aspects to parsimony: the refusal to give and the desire to gather. The attitude of meanness usually applied to well established copro symbols: money dominantly, books and time (Jones, 1913). On the other hand, collecting and hoarding is another manifestation of pleasure in retention. The tendency to hoard is often accompanied by a compulsion to give. Generous giving can be a reaction formation against the sadistic aspect of controlling and withholding or it can be a sublimated form of affectionate smearing (Jones, 1913).

#### 3.3.4. Faeces - money - gift - penis - baby?

"If one is not aware of these profound connections, it is impossible to find one's way about in the phantasies of human beings, in their associations influenced as they are by the unconscious, and in their symptomatic language. Faeces-money-gift-baby-penis are treated as though they meant the same thing, and they are represented

too by the same symbols"

(Freud, 1933 (a) ; 134).

The system-unconscious follows its own systemic laws of functioning which Freud has named the primary process (Freud, 1915(a)). In the unconscious, equivalences are established on the basis of perceptual identity which would be totally unacceptable to conscious, secondary process thinking. One such symbolic equation which is credible only if situated within the context of unconscious processes involves four terms: Faeces - money - penis - baby. Those four terms are interchangeable at the level of unconscious phantasy and the tertium comparationis which permits the equivalence is that of 'gift' or a part of the body-self which is detachable and can be given or done away with. (Freud, 1909, 1917).

When the young child has to give up its faeces owing to the cultural demands of toilet training, it displaces its anal erotism onto other possessions, and money, later, is the substitute par excellence for possessions (Freud, 1917). Young children adhere to the 'cloacal theory of birth': they believe that children are born anally, like faeces, and the straining, the release and production of something outside oneself is a prototype of birth (Freud, 1902(a)). Following the same logic, the faeces (the faecal stick) that stimulate the bowel membrane are, in psychic terms, a forerunner of the penis, and just as the faeces can be given up or parted with, the penis too can be taken away, renounced as in the castration complex.

This symbolic equation is extremely important in obsessional neurosis inasmuch as it suggests the possibility of the link between the anal-sadistic organization and the phallic-Oedipal organization. Both the progression and the regression from the one to the other is made

possible because such equivalences obtain at the level of drive representation: "In other people - obsessional neurotics - we can observe the result of a regressive debasement of the genital organization. This is expressed in the fact that every phantasy originally conceived on the genital level is transposed to the anal level - the penis being replaced by the faecal mass and the vagina by the rectum" (Freud, 1917 : 300).

### 3.3.5 Sexual ambivalence and the anal-sadistic organization

Active and passive aims of the sexual drive exist from the beginning that is, in the oral phase. However, for Freud (Freud, 1905), it is during the anal-sadistic stage that those two currents in mental life exist as antagonistic poles. Activity finds its prototype in the component instinct of mastery, and passivity in the stimulation of the anal mucous membrane. If the aim of the drive is generally understood as the activity through which satisfaction is obtained, (Freud, 1915(b) ) it is grasped more particularly at the level of unconscious phantasy. At that level a passive aim, translated into language, is of the order of: "Something is being done to me". On the other hand activity is of the order of "I do something to somebody" (Dolto, 1971). Three such dichotomies of aims mark the evolution of the drive: the passive-active dichotomy of the anal-sadistic phase, the phallic-castrated dichotomy of the Oedipal phase, and the masculine-feminine dichotomy of puberty and adolescence (Laplanche and Pontalis, 1973). During the anal-sadistic phase there is as yet no sexual differentiation between little boy and little girl. They both exhibit an equal admixture of passive and active aims in their object-relation (Freud, 1905; Mitchell, 1974). If the obsessional neurotic exhibits

conflicts over masculinity and femininity (Freud, 1909; Fenichel, 1946) it is due partly to the failure in negotiating the Oedipus Complex, and also to the all-important regression to the anal-sadistic organization with its specific aim dichotomy, and bi-sexuality.

### 3.3.6 Aggression and ambivalence and the anal-sadistic organization

Another psychological characteristic of obsessional neurotics is their deeply rooted conflicts over love and hate, that is, their ambivalence: " ... the chronic co-existence of love and hatred both directed towards the same person and both of the highest degree of intensity, cannot fail to astonish us" (Freud, 1909 : 239). Often the conscious proclamation of intense respect or love for the object is a reaction against the equally intense hatred and death-wishes which pervade at an unconscious level. The genital organization is marked by a fusion of love and hate, with love gaining the upper hand. The anal-sadistic organization, on the other hand, is marked by a defusion of love and hatred. In the regressive debasement of the genital trends which occur in obsessional neurosis, much of the libidinal impulses emerge as aggressive and destructive tendencies.

### 3.4 The Oedipus Complex and the Fixation-Regression Hypothesis

The defensive conflict against anal-sadistic id urges is prominent in the obsessional neurotic clinical picture. However, Freud never departed from his basic hypothesis that the Oedipus Complex, as the kernel of the transference neurosis, is the primary motivating force in obsessional neurosis: "Obsessional neurosis originates, do doubt, in the same situation as hysteria, namely, the necessity of fending

off the libidinal demands of the Oedipus Complex" (Freud, 1926 : 27). The following theoretical dilemma however poses itself: if it is the phallic-Oedipal situation which constitutes the starting point of obsessional neurosis, how then is the predominance of anal-sadistic tendencies, and the defences erected against them, to be explained?

Before answering this complex and crucial question, it is fit to briefly summarise the essential aspects of the Oedipus Complex, and to point out why it enjoys such an important explanatory status in Freudian theory with regard to the range of psychopathology covered by the concept of transference neurosis.

#### 3.4.1 The Oedipus Complex and the castration complex

During the pre-Oedipal phase which culminates in the Oedipus Complex proper there is as yet no psycho-sexual differentiation between little boy and little girl. Their psychological world is properly bisexual in the sense that it is dominated by 'phallic primacy' (Freud, 1923(b) ) and shows an equal admixture of passive and active aims in their object relationship. The Oedipus Complex is that crucial moment in the psychological history of every individual when a pivotal structuration takes place whose outcome is accession to psychological masculinity or femininity (Freud, 1923(a) (b), 1924, 1925(a), 1933, Mitchell, 1974), The Oedipus Complex thus constitutes a momentous event in the psychological history and structuration of the human subject.

Needless to say, there is a tendency to psychologise this Freudian notion and reduce it to an observable set of attitudes, longings and behaviours which are conscious. As the term complex itself indicates

the Oedipus Complex is primarily an organised group of ideas and phantasies of great affective force, which are either partly or totally unconscious (Laplanche and Pontalis, 1973). It can only be grasped from the vantage point of the theory of the unconscious, of psychical reality, which is best studied in the 'experimental crucible' of the psychoanalytic hour. Observation of children at best provides data which is corroborative.

The Oedipus Complex as a psychical structure is not the holy trinity of child, mother, father (Freud, 1923(a); Mitchell, 1974). It comprises four elements: the child's desire, the paternal and maternal object, and the most decisive castration complex. The set of relations which obtains between those four elements is complicated. The full Oedipal situation for both little boy and little girl shows both a positive and a negative instance in line with the theory of bisexuality (Freud, 1923(a) : 23-24). Thus, the little boy in his positive Oedipus complex identifies with father in his libidinal relation to the maternal object. As this object relationship gains in intensity, his identification with father takes on a hostile colouring, and changes into a wish to get rid of him in order to take his place with his mother. In his negative Oedipus complex the little boy identifies with the maternal object, and displays a feminine libidinal stance vis-a-vis the paternal object. Jealousy and hostility equally colour the identification with the maternal object. The same is true of the little girl. Every individual shows an admixture of both positive and negative Oedipal trends (Freud, 1923(a) ). It is the castration complex which intervenes in this complicated bi-sexual object-relationship so as to introduce a differentiation. In both little boy and little girl the Oedipus Complex leaves a precipitate in the

ego "consisting of these two identifications in some way united with each other" (Freud, 1923(a) : 24), and the relative intensity of the two identifications in any individual will reflect the preponderance in him of one or other of the two sexual dispositons. Thus it is a matter of degree and never an absolute primacy of masculinity or femininity in any particular individual.

There is an assymetry in the little boy as compared to the little girl's Oedipus complex, in that the castration complex brings about the dissolution of the boy's Oedipus complex, whereas the realisation of castration inaugurates the little girl's positive Oedipus complex (Freud, 1933). It is not within the scope of the present work to elaborate this important assymetry. The determining element of the castration complex, and the level at which it operates, will be schematically outlined in the case of the little boy.

Castration anxiety does not depend on actual, real threats of castration or punishment, although these are usually present in the history of any particular individual. Rather, it comes about when the idea that some have and some don't have a phallus, in other words, when the idea of the anatomical difference between the sexes becomes psychically meaningful (Freud, 1925(a)). The idea that the phallus is losable, or can be taken away, because some don't have it, is part of the sexual theories of children, just like the theory of 'phallic primacy' or the cloacal theory of birth are mythologies which answer the question of origins (Freud, 1908(a); Laplanche and Pontalis, 1968). Furthermore, the realisation of the fact that the phallus can be lost must be understood within the context of narcissism: castration is equivalent to a deep narcissistic wound. For the little boy to maintain his feminine identification with mother, his inverted

Oedipal position, entails not having the phallus. To maintain his masculine Oedipal position, and his rivalrous death wishes onto his paternal object, entails the anxiety of losing the phallus. In both cases, what is at question is an important narcissistic loss. Both his masculine and feminine positions have to be either attenuated or given up. This is achieved through the symbolic submission to castration (Mitchell, 1974).

In the case of little Hans, the doctor " ... did take away his penis ... but only to give him a bigger one in exchange for it" (Freud, 1909(a) : 100). The submission to castration is a symbolic one, it is of the order of a symbolic exchange. What is given up (the phallus, the desire for the maternal object, the possession of a narcissistically valued object) is compensated for in terms of a future promise ('One day you will be like your father'). The resulting precipitate in the ego, the introjection of the paternal object, what Freud called the super-ego, (Freud, 1923(A) ] contains that very dual element inherent in symbolic submission to castration. It contains both a compensation for the wounded narcissism in the form of an ego-ideal which is a mirror image of what the little boy can be like and a programme of identification which is ontologically pacifying, and a series of interdicts about what he may not desire and may not be. The super-ego's relation to the ego "is not exhausted by the precept: 'You ought to be like this'(like your father). It also comprises the prohibition: 'You may not be like this (like your father) - that is, you may not do all that he does; some things are his prerogative" (Freud, 1923(a) : 24).

As can be gleaned from this very schematic and partial portrayal of the Oedipus Complex, it is a moment of psychical structuration which

is of great importance in the psycho-sexual definition of any particular human subject. Its dominant anxiety centres around the possession of the phallus and the role of this representation within the context of the ego's narcissism, and the conflictual centre it constitutes as an object of intense desire or hatred within the context of a complicated set of object-relations.

#### 3.4.2 The fixation-regression hypothesis in obsessional neurosis

To return to the point made earlier (Section 3.4), the clinical picture in obsessional neurosis presents an admixture of both Oedipal and anal-sadistic trends. Oedipal and genital trends are evident in the form of conflicts over genital masturbation, rivalry with the member of the opposite sex, remnants of castration anxiety and strong super-ego ideals, to name a few. On the other hand, the defensive conflict against anal-sadistic urges, in the form of strong reaction formations, ambivalence and the anal symbols that pervade the clinical picture is prominent.



This co-existence of two libidinal organizations is explained in the classical etiological formula in terms of the fixation and regression to the anal-sadistic organization. The obsessional neurotic enters the phallic Oedipal organization, but the conflicts and anxieties thereof are too threatening. The ego makes use of a particular mechanism of defence: the drive regression. The drive regression to the anal-sadistic organization is the likeliest avenue because, in the course of its development, the drive has been fixated at the anal-sadistic stage (Freud, 1915-16(a)).


The concept of fixation is a descriptive one in Freudian theory

and contains no principle of explanation (Laplanche and Pontalis, 1973). It is a way of accounting for the empirical fact that the neurotic in particular, and the human subject in general, is marked by childhood experiences and retains an attachment, disguised to a greater or lesser extent, to archaic modes of satisfaction, types of objects and of relationships. Freud conceived of fixation as a tendency to repeat (Freud, 1920). On the other hand, fixation is linked to the concept of primal repression: "The libidinal current which has undergone fixation behaves in relation to later psychological structures like one belonging to the system unconscious, like one that is repressed" (Freud, 1911 : 67). Fixation is here conceived as a mode of inscription of certain ideational contents, experiences, images and phantasies which persist in the unconscious, and to which the drive remains bound.

Leaving aside for the moment the question of the factors which lead to an anal-sadistic fixation it is legitimate to ask the following question. If the notion of fixation is so important in understanding the drive-regression in obsessional neurosis, and if it is plausible to assume that the anal-sadistic organization grew at the expense of the phallic-Oedipal organization with the consequent result of a likely failure to negotiate the Oedipal conflicts, is it not plausible to shift the etiological weight onto the anal-sadistic fixation as such? In other words what proves that the Oedipus Complex plays such an important role in obsessional neurosis and that the regression hypothesis is so crucial? Couldn't obsessional neurosis be due to a developmental inhibition as a result of the anal-sadistic fixation?

It is important to address ourselves to this problematic and crucial issue since Freud himself did so in two different contexts (Freud, 1913, 1926).

In his "Disposition to obsessional neurosis" (Freud, 1913), Freud outlined two possible courses for obsessional neurosis:  those which start at an early age (unspecified) and run a chronic course, and those which start much later in life after the relinquishing of a well-established genital sexual organization (Freud's well-known example of the menopausal woman). Of the former Freud writes: "In these other cases, once the sexual organization which contains the disposition to obsessional neurosis (i.e., the anal-sadistic organization) is established it is never afterwards completely surmounted" (Freud, 1913 : 312). Of the latter case he writes "In our case it was replaced to begin with by the higher stage of development, and was then reactivated by regression from the latter" (Freud, 1913 : 312). Freud here seems to oppose fixation and regression as two possible  courses of obsessional neurosis. It is easy to show that at that time Freud had not yet fully elaborated the notion of the Oedipus Complex (Freud, 1919, 1923(a), 1923(b), 1925, 1933) and that he in fact was making a very restricted usage of the concept of regression in a case in which it is demonstrated in its pristine clarity.

Much later in his "Inhibitions, symptoms and anxiety" (Freud, 1926), the problem is no longer posed in the same terms, but Freud does again open up the question of the etiological emphasis: "Perhaps regression is not the result of a constitutional factor but of a time-factor. It may be that regression is rendered possible not 

because the genital organization of the libido is too feeble but because the opposition of the ego begins too early, while the sadistic phase is at its height" (Freud, 1926 : 28). It appears that Freud in this passage de-emphasises the role of the Oedipus Complex, and instead emphasises the role of precocious ego development and thus of the fixation it leads to. However, he goes on: "I am not prepared to express a definite opinion on this point, but I may say that analytic observation does not speak in favour of such an assumption. It shows rather that by the time an obsessional neurosis is entered upon, the phallic stage has been reached" (Freud, 1926 : 28).

Freud thus clung tenaciously to the hypothesis of the regression from the phallic-Oedipal, as the kernel of obsessional neurosis:

"It is perhaps in obsessional cases more than in normal or hysterical ones that we can most clearly recognise that the motive force of defence is the castration complex and what is being fended off are the trends of the Oedipus Complex" (Freud, 1926 : 28). This hypothesis is adhered to by all those who subscribe to the classical etiological formula. Nevertheless, it is not superfluous to adduce the evidence which does corroborate this pivotal hypothesis.

In the psychoanalytic literature it is Fenichel (1934, 1946) who has addressed the question of the 'experimental proof' of regression most extensively (Nagera, 1976). His starting point is that the mere co-existence of Oedipal and anal-sadistic trends is not a convincing proof that a regression has occurred. Such an observation could equally be used to corroborate the hypothesis that the phallic-Oedipal stage was endowed from the very beginning with strong pregenital qualities because of the anal-sadistic fixation. Fenichel advances the following proof

- In some ideal cases of typical obsessional neuroses, which are few, the full attainment of the phallic Oedipal structure and the subsequent fateful regression to the anal-sadistic fixation is demonstrable.
- Using the archeological model which Freud was so fond of Fenichel points out that the regression can be observed in statu nascendi. Thus, in analytic practice, after uncovering a whole world of anal-sadistic experiences going back to the earliest years of childhood, there appear elements of an earlier period, purely phallic in organization which have been shattered by castration anxiety: "It is therefore important not to be misled into thinking that the first memories refer to anal sadistic impulses ... they are not original, but regressive in nature" (Fenichel, 1934 : 147).
- In rare cases of hysteria, in which, owing to external or internal factors, the genital life is given up, the the hysterical neurosis is replaced by an obsessional neurosis.
- The failure of the regression, as a defence, in warding off castration anxiety can be observed: because of the regression the patient develops an anal castration anxiety owing to the unconscious equation faeces = penis.
- Other indirect proof of the role of the Oedipus Complex is given by Freud himself. He observed that obsessional neurosis only 'overdoes the normal methods of getting rid of the Oedipus Complex' (Freud, 1926 : 29). In obsessional neurosis the destruction of the Oedipus Complex is accompanied by a regressive degradation

of the libido. The normal process of super-ego formation, of the erection of aesthetic and ethical barriers within the ego, becomes exaggerated: the super-ego becomes exceptionally unkind, and strong reaction formations of conscientiousness, pity and cleanliness are formed. The harsh super-ego manifests itself particularly strongly in condemning the temptation to continue genital masturbation, an Oedipal trend (Freud, 1926 : 29).

The regression due to the phallic-Oedipal conflict is a cornerstone of the classical hypothesis. Freud hinted at the possibility that the fixation might be all-decisive, but only to repudiate this hypothesis. It is generally acknowledged that the greater the fixation, the most likely will the regression take place as a defence against Oedipal conflicts.

As regards the anal-sadistic fixation the following contributing factors are usually advanced by Freudians. These factors can be divided broadly between biological endowments, and the quality of environmental experiences. Thus a biological predisposition towards heightened anal erogeneity or anal-sadism is posited (Fenichel, 1946). However, such an hypothesis rests on speculation rather than fact, as it cannot be proven. Secondly, unusual gratification, unusual frustrations or a combination of both during the anal phase are appealed to as causative factors in fixations (Fenichel, 1946). Traumatic happenings, seductions and undue interference by early and strict bowel training do contribute (A. Freud, 1966). But they are not a necessary ingredient in the biography of every obsessional neurotic. On the whole, the theory of fixation is not satisfactory and is tinged with vagueness and non-specificity.

### 3.5 The Consequences of Regression on the Super-Ego in Obsessional Neurosis.

An extremely severe and harsh super-ego is one of the defining characteristics of obsessional neurosis. Freud saw fit to make a rapprochement between the super-ego of the obsessional neurotic and that of the melancholic. "The reproaches of conscience in certain forms of obsessional neurosis are as distressing and tormenting as in melancholia, but here the situation is less perspicuous" (Freud, 1923(a): 43) with the notable exception, however, that in obsessional neurosis the ego is strong enough to retain an object cathexis as a result of which the total narcissistic retreat is absent, and "the obsessional neurotic, in contrast to the melancholic, never in fact takes the step of self-destruction, it is as though he were immune against the dangers of suicide ..." (Freud, 1923(a) : 43).

The harshness of the super-ego is a direct consequence of the id regression to the anal-sadistic: "We can either simply accept as a fact that in obsessional neurosis a super-ego of this kind emerges, or we can take the regression of the libido as the fundamental characteristic of the affection and attempt to relate the severity of the super-ego to it" (Freud, 1926 : 29-30).

The drive regression entails a defusion of the drive. The terms fusion and defusion are descriptive metapsychological concepts which lack specificity. The attainment of Oedipality is characterised by a greater fusion of the aggressive aspects of the drive: "Making a swift generalisation, we might conjecture that the essence of a regression of the libido (e.g., from the genital to the anal-sadistic phase) lies in a defusion of instincts, just as conversely,

the advance from the earlier phase to the genital one would be conditioned by an accession of erotic components" (Freud, 1923(a) : 32). As a result of this defusion, the aggressive and libidinal drives pursue their aims independently of each other. As a result, loving is often associated with destroying, which accounts for the overbearing ambivalence of the obsessional neurotic. X

Obsessional neurosis exaggerates the normal process of getting rid of the Oedipus Complex (Freud, 1923(a) ). The super-ego is normally a corollary of the decline of the Oedipus Complex. The essential feature of the dissolution is that Oedipal object cathexes are given up and replaced by identifications in the form of an ego-ideal. However, the setting up of an identification is in the nature of a de-sexualisation, or a sublimation, as a result of which the libido available to bind the aggressive drive is lessened. Thus, according to Freud, even in normal super-ego formations a defusion of love and hate does take place, with the consequent sense of guilt which is unmistakably harsher than the real parental prohibitions: "It now seems as though when a transformation of this kind takes place, an instinctual defusion occurs at the same time. After sublimation the erotic component no longer has the power to bind the whole of the destructiveness that was combined with it, and this is released in the form of an inclination to aggression and destruction. This defusion would be the source of the general character of harshness and cruelty exhibited by the ideal - its dictatorial 'Thou shalt' " (Freud, 1923(a) : 44-45). In the case of obsessional neurosis owing to the regression which entails a drive defusion, the aggressive components are considerably reinforced, and the super-ego is even stricter and harsher.

The obsessional neurotic's super-ego presents archaic, sadistic and automatic features. It obeys the 'talion principle' and the rules of word magic (Fenichel, 1946). Alexander (1930) was the first to point out that the moral masochism of the obsessional is in fact a pseudo-morality which doesn't meet the moral standard of a true super-ego. Rather, it exhibits a feature which Alexander (1930) called: the corruptibility of the super-ego. The prominent atonements of the obsessional neurotic act as a license to engage in other transgressions, with the resulting alteration of instinctual and punitive acts. The super-ego, because of its harshness, allows the prohibited impulses to obtain satisfaction: it is corruptible and manifests a pseudo-morality.

The presence of an archaic super-ego in obsessional neurosis points to the fact that there has been a degradation of the mature, genital super-ego. It is acceptable to use the term super-ego regression to describe this deterioration consequent upon drive regression. But if there is a regression at the level of the super-ego, it is important to specify the type of structure to which the super-ego has regressed. Terms like archaic, pseudo-moralistic and harsh are anthropomorphic and merely point out the fact that the obsessional neurotic does not have a mature super-ego, but do not specify the differences that do exist. Furthermore, if the super-ego is a precipitate resulting from the dissolution of the Oedipus Complex, what type of structures precede it, and in what way are they different from the mature genital super-ego? Do they deserve the name super-ego?

In a generally acclaimed paper (Nagera, 1976) it is Weissman who has done the most to clarify this grey area in Freudian theory. In

his paper "Ego and super-ego in obsessional character and neurosis" (Weissman, 1954), he outlines the differences between the super-ego forerunner, or precursor, and the super-ego proper: "To say that it is a forerunner or a precursor is, in my opinion, least incorrect. In the limited sense that they mean something that precedes, they are acceptable; in the ultimate sense of a sign of things to come, they are less so. The term super-ego should be restricted to the ultimate, genital super-ego because of the structural and developmental differences" (Weissman, 1954 : 539). The main differences between archaic precursor, and super-ego proper, are as follows:

- The function of the precursor is to provide the ego of the infant with a means of sharing the power of its parents, and their protection against its instinctual prephallic demands. The function of the super-ego is to bring about the resolution of the Oedipus Complex.
- The precursor contains introjected images of parental attitudes and prohibitions in the ego. The cathexes of these images are transient and reversible, and their position in the ego is undone by the mechanism of projection. The super-ego proper is formed by identification with parental images representing both parental ideal, and parental super-ego, and contains the highest level of parental prohibitions. Thus the mature super-ego introjects are more permanently internalised, the internal object is more independent of the external object, and more differentiated from the ego. The precursor's introjects are part of the ego, and less independent of external objects.

- In the forerunner, the aggressive energy attached to the prohibiting introject is least neutralised, and approximates instinctual qualities. In the mature super-ego, the aggressive energy attached to the parental introject is more neutralised and the object libido attached to the ego ideal is desexualised.
- The forerunner threatens with danger of loss of the love object, and of loss of love. The mature super-ego threatens with castration as well as the loss of self-esteem. The mature super-ego has the positive aspect of producing feelings of self-approval; well-being, under the archaic forerunner, seems to be absence of unpleasure.

(Weissman, 1954 : 529-43).

This enlightening delineation by Weissman has the advantage of helping the clinician in assessing the degree of super-ego regression which has occurred in obsessional neurosis. Just as in the case of the drive, an admixture of phallic-Oedipal and anal-sadistic trends obtain, in the case of the super-ego regression, the admixture of archaic and mature trends co-exist.

### 3.6 The Ego in Obsessional Neurosis

There are three aspects to the question of the ego in obsessional neurosis. Firstly, the ego makes use of specific defence mechanisms which determine the very form of the symptomatology obtained in the clinical picture. In other words, the ego-defence mechanisms determine the outcome of the important drive regression. They will be reviewed in a separate section (refer to Section 3.7). Secondly,

it is legitimate to ask whether the drive regression entails an ego regression, and if it does, to specify the modifications that ensue. Thirdly, following Freud's lead on the topic (Freud, 1926), the notion of precocious or premature ego development during the anal-sadistic phase has received a great deal of attention from ego-psychologists (Hartmann, 1950; Weissmann, 1954; A. Freud, 1965, 1966; Sandler and Joffe, 1965). The hypothesis of precocious ego development is an important etiological ingredient in obsessional neurosis. In this section the last two questions will be dealt with.

### 3.6.1 Ego modifications in obsessional neurosis

If it is possible to speak of super-ego regression in obsessional neurosis, is there a regression in the ego organization? In psychoanalytic circles it is generally accepted that the term ego regression is reserved for the types of changes observed in organic and psychotic pathologies. In such pathologies the ego is severely split and unintegrated. Sandler and Joffe (1965), following Hartmann (1950), make a useful distinction between the structural and functional aspects of the ego, and argue that in obsessional neurosis there is a functional regression but no structural regression. The functional regression shows itself in the invocation of specific defence mechanisms and in certain archaic modes of ego functioning. Structurally, however, the ego remains intact: it is differentiated from the id against whose urges it wages a defensive battle, it remains in touch with reality and retains insight, and the ego-ideals held up by the super-ego, although some may be archaic, persist, and are differentiated from the ego (Sandler, and Joffe, 1965).

The modifications in ego-functioning are as follows:

- In relation to the super-ego the ego organization exhibits a 'double-front' (Fenichel, 1946). On the one hand, it is compliant with the super-ego dictates which depict its weakness. On the other hand, it is rebellious and defies the super-ego dictates which indicate its strength. This double front of the ego is most evident in biphasic symptomatology.
- It is at the level of the thinking process that regressive ego-functioning shows itself most clearly. The thinking function shows a cleavage between a part which remains intact, logical, and retains insight about the 'irrational' symptomatology, and a part which is permeated by archaic or regressed modes of thinking. Winnicott refers to the "concept of a split-off intellectual functioning" as a central feature of obsessional neurosis (Winnicott, 1966).

*thinking*

The obsessional neurotic behaves as if thinking is equivalent\* to doing. Thus words or thoughts have the power to kill or resurrect, they can perform miracles and turn time back. This is a characteristic which Freud (1909) named the 'omnipotence of obsessional thinking'. Since psychical events have such an overbearing reality, the obsessional neurotic is often superstitious, and continuously looks for indices which will validate his predictions and presentiments. Thus part of the ego is regressed at a narcissistic and megalomaniac level of functioning (Freud, 1909; Ferenczi, 1913).

- This regressed mode of thinking is accompanied by its pervasive counterpart. If thoughts are so omnipotent they can equally be

used to master thoughts and things. The core of the 'magic of names' is: "He who knows a word for a thing, masters the thing" (Fenichel, 1946). The magical formula Glesijamen (refer to Section 3.1.2) of the Rat-Man exemplifies this magical investment of words. Thus the fear of the omnipotence of his thoughts make the obsessional neurotic even more dependent on his thinking. Magical formulae, belief in sacred numbers, secret utterances and obsessional brooding on obscure and inconclusive topics become ways of mastering the terrifying omnipotence thoughts. This attempted mastery of words by words and thoughts by thoughts is linked to the prominence of intellectualisations and rationalisations in the ego's defences. Compulsive thinking is abstract thinking par excellence, isolated (split off) from the world of things and from the world of feelings. There is a predilection for supra-sensual topics, obtuse and doomed to be inconclusive (Freud, 1896, 1909).

The much vaunted intellectual prowesses or superior intelligence of obsessional neurotics is under critical scrutiny today (Barnett, 1966) precisely because part of their thinking processes are regressed, magical, archaic and absorbed in a defensive struggle.

Therapy [ One interesting aspect of obsessional neurosis is that the attempted mastery of thoughts by thoughts becomes in the course of time a substitute for instinctual gratification. Freud pointed out that in obsessional thinking, the epistemophilic urge is prominent, and becomes a sublimated off-shoot of the drive for mastery exalted into the intellectual sphere. Thus obsessional thinking often shows

its sadistic colouring. On the other hand, thinking, in its attempt to ward off sexual impulses, itself becomes sexualised, and the sexual pleasure normally attached to the content of the thought is shifted onto the act of thinking itself (Freud, 1896, 1909, 1913(b) ).

### 3.6.2 The precocity of ego-development

Freud made two references to the role of the precocious ego in obsessional neurosis: " ... I suggest the possibility that a chronological outstripping of libidinal development by ego development should be included in the disposition to obsessional neurosis" (Freud, 1913 : 325). Thirteen years later he tentatively hypothesised the "early opposition of the ego, whilst the sadistic phase is at its highest" (Freud, 1926 : 28 ).

What Freud put forward as tentative hypothesis, has been accepted as fact by ego-psychologists, and developed by particular members of this school of thought. The argument goes as follows: a premature development of the ego during the anal-sadistic phase results in an early defensive conflict which predisposes the ego to develop defence mechanisms that typify obsessional neurosis. This premature conflict increases the possibility of drive fixation (Hartmann, 1950; A. Freud, 1966; Nagera, 1976; Sandler and Joffe, 1965). Hartmann (1950) pointed to the need for more detailed and specific statements as regards the ego functions which have undergone a precocious or retarded development. He suggested that intellectual and defensive functions of the ego develop prematurely, whereas tolerance for unpleasure is retarded (Hartmann, 1950).

Sandler and Joffe (1965) have gone much further in the plea for specificity. They not only point out a specific ego disposition in employing a certain type of defensive organization, but suggest further that "this defensive organization is latent and inherent in a particular mode or style of perception or cognition" (Sandler and Joffe, 1965 : 432).

The style of ego functioning is not to be confused with character structure. It refers rather to those cognitive and perceptual modifications manifest during the anal phase of development. They mimic the typical somatic drive discharge. Thus, in the development of verbalisation, speech, and thinking, the characteristics of the phase can be discerned: expression is controlled, there is delay in discharge, and inappropriate elements have to be held back. In perceptual development the phenomenon of the 'clearing of the perceptual screen' is observed and its anal parallel with the drive aim of evacuation is obvious. Sandler and Joffe do not put into question the classical etiological formula, but maintain that it is not complete if a particular type of ego perceptual and cognitive style is not invoked. Thus they adduce a new factor in the etiological formula, that is, an anal, functional fixation of the ego: "Both drive fixation and functional fixation of the ego may occur at the anal-sadistic phase, and we would suggest that this is the case which obtains in the individual who is prone to develop an obsessional neurosis" (Sandler and Joffe, 1965 : 436).

### 3.7 The Ego Mechanism of Defence

Regression as an ego defence mechanism operates at the level of

the drive. The ego in obsessional neurosis exhibits a formidable array of defences, all operating at the level of the thought process. If repression is the major defence in hysteria, it only plays a partial role in obsessional neurosis. Displacement is often mentioned as an ego defence in obsessional neurosis (A. Freud, 1966) but, strictly speaking, displacement is not an ego-defence. Displacement and condensation in conjunction are dominant modes of the functioning of the system-unconscious, and are at work in any unconscious manifestation. They are ways of getting around censorship and the ego defences (Freud, 1916-17(b) ).

### 3.7.1 Repression

The usage of the term repression in obsessional neurosis is confusing since Freud uses it at times to mean repression proper, and at times to mean defence in general (Nagera, 1976). Here the term repression is used in the sense of repression proper.

In hysteria, the amnesia of childhood complexes and experiences is extensive. In obsessional neurosis the amnesia is a very incomplete one, and many unconscious phantasies are present in consciousness, albeit in a distorted form (Freud, 1909). This lack of repression proper, however, is relative. Often patients are not able to tell what their obsessions consist of. The obsessions have a colourless, vague, dreamlike quality about them and it often takes a good deal of analytic work to remove the repressions sufficiently for the full text to become legible (Freud, 1926; Fenichel, 1946).

Therapy

Repression proper operates through the countercathexis of a substitute formation which appears in the ego in the form of a reaction formation: increased conscientiousness (Freud, 1915(c) ). If successful at first, the primary defence soon fails, and both the idea and the affect appear in consciousness in modified form (refer to Section 3.1.2). Repressed ideas are displaced onto something small or indifferent. The mechanism of 'displacement onto trifles' features prominently in obsessional neurosis (Freud, 1915(c), 1926).

### 3.7.2 Reaction formation

"The reaction-formation in the ego of the obsessional neurotic which we recognize as exaggerations of normal character-formation, should be regarded, I think, as yet another mechanism of defence and placed alongside of regression and repression" (Freud, 1926 : 29). Reaction formations are deeply entrenched in obsessional neurosis. However, they are rarely successful, and the obsessional patient is occupied in a perpetual struggle between reaction formation and the original impulse.

### 3.7.3 Isolation

Isolation and undoing are the ego's two main defences in the light of the failure of repression. Isolation occurs in two forms: the isolation of affect from idea, and the isolation of thought-content.

Thinly disguised anal-erotic or sadistic impulses make their way into consciousness and can do so because they are isolated from their

affective change. The affect instead is displaced onto trifles. Many obsessional neurotics appear to be cold, abstract and emotionless as a result of the very isolating propensity which renders the task of free association so difficult for them. Ideas and affect are not allowed to make contact or 'touch' each other.

Isolation of thought-content is equally a favoured mechanism: "In many different forms of obsessional neurosis forgetting is mostly restricted to dissolving thought-connection, failing to draw the right conclusions and isolating memories" (Freud, 1926 : 149). This results in an inhibition in the expression of a gestalten (Fenichel, 1946).

Freud points out the 'magical' quality of isolation: "But in endeavouring to prevent association and connection of thought, the ego is obeying one of the oldest and most fundamental commands in obsessional neurosis, the taboo of touching" (Freud, 1926 : 35). The taboo of touching, the avoidance of contact and the fear of contagion features prominently in the burdensome ceremonials of obsessional neurosis: 'dirty' things must not touch 'clean' ones, 'dirty' thoughts 'clean' ones. Freud points to the importance of touching in both the destructive and erotic drives, and it is not surprising that touching is so strongly proscribed in obsessional neurosis, as it is so well suited to become the central point of a system of prohibitions.

### 3.7.6 Symbolic undoing

Symbolic undoing of what has been done is a type of negative magic. Freud made the explicit link between undoing, and the symbolic motor activity of 'blowing away' not only the consequences of some

event, but the event itself: "I choose the term to 'blow away' advisedly, so as to remind the reader of the part played by this technique not only in neuroses but in magical acts, popular customs and religious ceremonies as well" (Freud, 1926 : 33). Symbolic undoing is an attempt to get rid of something by 'making it not have happened': it is essentially irrational and reveals a strong element of omnipotence.

This ego defence is at the centre of a variety of obsessional symptoms. Compulsive washing thus is a way of blowing away the 'dirtying' action. The obsession with repeating an action a number of times is a way of undoing another action: eventually, pure counting may replace the actual symbolic action (Fenichel, 1946). Even numbers often signify good actions, and are employed to undo bad actions symbolised by odd numbers. Biphasic symptoms such as the placing and removing of stones from a street, and the closing and opening of taps are manifestations of the same phenomenon. Thus what was done with an instinctual intention must be undone with a super-ego attitude. The various penance rituals are equally aimed at undoing the bad deed.

It is evident that such ego functions play a very important role in determining the outcome of the drive regression. The specific ego defence mechanisms are an essential ingredient of the etiological formula.

### 3.8 The Age of Onset and the Course of Obsessional Neurosis

Freud made a distinction between two types of development of obsessional neurosis: one in which isolated manifestations appear

between the age of six and eight approximately, that is, once the latency period has been established. Those first manifestations are either obsessional ceremonials which "already exhibit features which will emerge so distinctly if a later serious illness follows" (Freud, 1926 : 23), or they are prototypes without necessarily any obsessional symptoms (refer to Section 3.9). However, it is the advent of puberty which opens up a decisive chapter in the history of obsessional neurosis: "The genital organization which has been broken off in childhood starts with great vigour. But, as we know, the sexual development in childhood determines what direction this new start at puberty will take" (Freud, 1926 : 30). Thus the new libidinal impulses follow the course prescribed for them by regression and emerge as aggressive and destructive tendencies. Interests in genital masturbation and sexuality, owing to regression, provoke intense conflicts: "The ego will recoil with astonishment from promptings to cruelty and violence which enter unconsciousness from the id, and it has no notion that in them it is combating erotic wishes including some to which it would not otherwise have taken exception" (Freud, 1926 : 30). It is this type of obsessional neurosis which runs a chronic course more or less without interruption from adolescence onwards (Fenichel, 1946).

On the other hand, there is a type of acute obsessional neurosis (Freud, 1913; Fenichel, 1946) whose onset is contingent upon clear external or internal factors, such as the menopause or trauma. Onset is usually late and the neurosis tends to disappear. This is an atypical form of obsessional neurosis.

Since the regression from the phallic-Oedipal to the anal-sadistic

fixation is the determining etiological factor, the question of the age of onset has experimental relevance. Within the logic of the classical formula it cannot be expected that the onset of an obsessional neurosis would occur in a pre-Oedipal phase of development. Psychodynamically speaking, a pre-Oedipal obsessional neurosis would be a contradiction in terms, since obsessional neurosis entails the attainment of the phallic-Oedipal organization and the drive regression as a neurotic solution to the Oedipus Complex.

### 3.9 Obsessional Neurosis, the Infantile Neurosis and Transference Neurosis

In this last section, the view will be put forward that obsessional neurosis, according to the classical theory, is a psychopathological configuration which can be defined not only in terms of its overt symptomatology but especially in terms of its internal structure or internal fabric. If this internal fabric is taken into consideration, it also allows for the delimitation of the range of obsessional neurosis as a specific form of psychopathology, distinct from other types of psychopathology.

Freud always considered obsessional neurosis as a transference neurosis, alongside hysteria and phobias (Freud, 1916-17(a), 1923, 1926). What does the concept of transference neurosis entail? Transference neurosis is a particular form of psychopathology whose leading organizing force is the 'infantile neurosis'. The infantile neurosis does not refer merely to clinically manifest symptomatology which appears in the course of childhood. Freud uses this concept in a metapsychological

sense which gives it a theoretical status (Freud, 1909, 1909(a) ).

The infantile neurosis "as the endopsychic structure, which is the model of the transference neurosis, is the metapsychological concept which underlies his (Freud's) clinical findings regarding the role of the Oedipus Complex in normal development and in the psychoneuroses" (Tolpin, 1970 : 273).

In his Rat-Man case, Freud demonstrates very clearly how the later obsessional neurosis was preceded by a neurotic core, a neurotic prototype which had crystallised during the patient's sixth or seventh year as an outcome of his Oedipus Complex, that is, of his infantile neurosis (Freud, 1909). At that age already the Rat Man was under the sway of a compulsive voyeuristic desire to look at naked women, followed by a feeling of anxious dread that something terrible would happen to his father if he had to think those thoughts, and the urge to do something to avoid the disaster (Freud, 1909 : 162). Of this latency phase prototype Freud writes: "The events in his sixth or seventh year which the patient described in the first hour of his treatment were not merely, as he supposed, the beginning of his illness, but were already the illness itself. It was a complete obsessional neurosis, wanting no essential element, at once the nucleus and the prototype of the later disorder, - an elementary organism as it were the study of which could alone enable us to obtain a grasp of the complicated organization of his subsequent illness" (Freud, 1909 : 162 - our emphasis). This prototype was initially circumscribed, and it is only at the age of twenty-five that the neurosis grew in intensity to become a crippling factor in his life.

The point made here is that the concepts of transference neurosis, infantile neurosis, and the Oedipus Complex, are intrinsically

related. In 1919, Freud wrote: "Infantile sexuality, which is held under repression, acts as the chief motive force in the formation of symptoms; and the essential part of its content, the Oedipus Complex is the nuclear complex of the neurosis" (Freud, 1919 : 204).

Obsessional neurosis according to the classical viewpoint is a transference neurosis which entails that its underlying organizing force is the Oedipus Complex and the particular resolution of the conflict thereof.

Obsessional neurosis as a transference neurosis has a structural specificity and a range of application which can be clearly articulated. The classical viewpoint entails that it is not possible to define obsessional neurosis purely in terms of overt signs and symptoms, but that the endopsychic structure which is an essential ingredient in the formation of the symptoms must be included in the very definition of the neurosis. More specifically, this endopsychic structure is composed of the following elements:

- A sufficiently unimpaired attainment of the phallic-Oedipal stage with a specific resolution of the latter (Eissler, 1953). In obsessional neurosis, the drive regression to anal-sadistic fixation points is the dominant feature of this faulty solution. This entails an admixture of both Oedipal, genital and anal-sadistic conflicts on an intrinsic part of the clinical picture. It is never a case of a complete and total regression to the anal phase, but rather a case of a regressive analisation of Oedipal object relationships and conflicts (Sandler and Joffe, 1965). This does not deny that there might be residual representatives of anal conflicts in obsessional neurosis, but it is the way

in which those conflicts have been integrated into the neurosis which is important (Nagera, 1976). Furthermore, the dominance of the anal sadistic fixation of the drive has to be evident (Nagera, 1976).

- A relatively coherently organized ego, which has potential for optimal functioning, a capacity to maintain an adequate relationship with reality, realise potentials and to attain the genital stage of adulthood (Eissler, 1953). The distinction between the functional and structural aspects of the ego (refer to Section 3.6.1) is important in this respect. The functional regression of the ego entails the deployment of a specific range of ego defences such as reaction formation, isolation, undoing and intellectualisation, and not more fundamental splitting mechanisms such as introjection and projection. Furthermore, the ego is well differentiated from the id, and in no danger of annihilation or complete disintegration, which would entail the usage of radical splitting as a mode of defence with the consequence that the introjects have retained their id quality.
- A high degree of super-ego conflict with some elements of the super-ego having retained their maturity whilst others are more archaic introjects (refer to Section 3.5) which retain their aggressive quality. Thus certain ideals held up by the super-ego introject persist and are permanent. There is a differentiation between ego and super-ego structure.
- Finally, it appears that the age of onset is an important aspect in the diagnosis of an obsessional neurosis, since as a transference neurosis it would be a result of the Oedipus Complex.

Hence, classical theory would not predict an obsessional neurosis in the first phase, or pre-Oedipal phase of childhood.

As regards its range, obsessional neurosis would then be distinct from other types of psychopathologies, such as the narcissistic personality, the borderline state, functional psychosis, all of which involve pre-Oedipal fixations with significant ego modifications more severe and more regressed than those outlined in the context of obsessional neurosis (Tolpin, 1970). Such pathological configurations have an endopsychic structure which the infantile neurosis and the Oedipus Complex fail to account for.

## CHAPTER 4

### Klein's Writings on Obsessional Neurosis and the Psychotic Anxiety-Situations of the First Year of Life

#### 4.1 Chronology of M. Klein's writings on obsessional neurosis.

M. Klein's writings on obsessional neurosis and obsessional mechanisms appear in two chapters of her "Psychoanalysis of children" (Klein, 1932). Chapter 3, entitled "An obsessional neurosis in a six-year old girl" is a case-study of a child patient named Erna. Chapter 9 entitled "The relation between obsessional neurosis and the early stages of the super-ego" is a more theoretical work.

As is well known, Klein's own work underwent major modifications. It can be subdivided into two broad periods (Segal, 1979): an early period extending from 1919 to 1934, and the period post 1934. The crucial point of departure centres around the publication of her famous essay: "A contribution to the psychogenesis of manic depressive states" (Klein, 1934) in which she articulated the pivotal notion of the depressive position. In 1946, in yet another seminal paper entitled "Notes on some schizoid mechanisms", she made full use of the concept of the paranoid-schizoid position which precedes the depressive position, and characterises the very first few months of the infant's emotional life.

A major objection may thus be raised as to the validity of her early views on obsessional neurosis, in the light of the subsequent modifications in her conceptual framework. Although it is not

within the scope of such a thesis to trace in detail the implications of the post-1934 modifications for her earlier work, it is nevertheless important to demonstrate that her earlier views on obsessional neurosis are not affected in any significant or invalidating way by those theoretical alterations.

Two lines of argument are followed to demonstrate the point. Firstly, Klein's articulation of the two positions affect mostly her views on the first year of life. Thus the concepts of persecutory anxiety, depressive anxiety and the various defence mechanisms used in modifying them become more succinctly delineated and articulated (Segal, 1979). But obsessional mechanisms (the link between them and obsessional neurosis will be shown in Chapter 5) appear during the second year of life, that is at the beginning of the anal phase of development (Klein, 1932, 1940, 1952) and, as such, are not directly affected by those modifications. Furthermore, it can be argued that, as Klein's ideas on the first year of life developed and were more succinctly enunciated, the role of obsessional mechanisms with respect to the anxieties emanating from the first year of life became clearer.

Secondly, Klein herself never repudiated her earlier writings on the subject. She in fact reasserted their validity and expanded on them so as to bring them more in line with her later theoretical views as the following quotations, which span twenty years of her writings, indicate: "The process of modification of a phobia is, I believe, linked with those mechanisms upon which the obsessional neuroses are based and which begin to be active in the later anal stage. It seems to me that obsessional neurosis is an attempt to cure the psychotic conditions which underlie it, and that in infantile neuroses both obsessional mechanisms and mechanisms belonging to a

previous stage of development are already operative" (Klein, 1932 : 226). In this quotation Klein explicitly assigns to obsessional mechanisms, on which obsessional neuroses are based, the role of modifying or curing the psychotic conditions which underlie them.

Twenty years later, in her article "Some theoretical conclusions regarding the emotional life of the infant" (Klein, 1952), an article which is generally considered to be a systematic exposition of a large part of her later work (Laplanche and Pontalis, 1973), Klein has the following to say: "During the second year, obsessional trends come to the fore; they both express and bind oral, urethral, and anal anxieties. Obsessional features can be observed in bed-time rituals, rituals to do with cleanliness or food and so on, and in a general need for repetition ... These phenomena, although part of the child's normal development can be described as neurotic symptoms. The lessening or overcoming of those symptoms amounts to a modification of oral, urethral and anal anxieties, this in turn implies a modification of persecutory and depressive anxieties" (Klein, 1952 : 226). Thus obsessional trends or mechanisms are assigned the major developmental function of modifying both persecutory and depressive anxieties, that is, the type of anxieties which characterise the paranoid-schizoid and the depressive position respectively, in the first year of life.

It can thus be gleaned from the above that Klein assigned the same role to obsessional mechanisms, with the crucial difference that in her later work the 'psychotic anxieties' of the first year of life are more clearly delineated and articulated with the formulation of the two positions.

In yet another seminal article on the depressive position:

"Mourning and its relation to manic depressive states" (Klein, 1940), in which Klein relates the obsessional defence to the manic defence, she makes a direct reference to her earlier writings on obsessional mechanisms: "I have described elsewhere<sup>2</sup> my conclusion that the obsessional mechanisms are a defence against paranoid anxieties as well as a means of modifying them and here I will only show briefly the connection between obsessional defences and the manic defences ..." (Klein, 1940 : 318). And as the footnote indicates, the 'elsewhere' refers to Chapter IX of her "Psychoanalysis of children", that is, the theoretical chapter on obsessional neurosis (Klein, 1940 : 318, footnote).

It is evident that as Klein's conceptions on early psychotic anxieties became more elaborated, she felt the need to articulate more precisely the relation between obsessional mechanisms and her new conceptions. But the role and mode of operation of obsessional mechanisms are not altered.

At this juncture it is important to give a comprehensive account of what is meant by early psychotic anxieties in Kleinian theory, since they play an important role in obsessional neuroses.

## 4.2 Early psychotic anxieties

M. Klein's views on the first year of life altered significantly. Her later and more mature views will be reviewed in depth so as to gain a thorough understanding of the notion of psychotic anxieties. However, for purpose of comparison and clarification, the essential elements of her early and late work have been mapped out (refer to Charts I and II). They constitute extensive summaries of these two broad periods of her work to which the reader will be referred as the argument unfolds.

### 4.2.1 The concept of position

One of the features which distinguishes Klein's later work is her usage of the concept of position. The notion of position indicates a shift of emphasis onto object relations which entails a set of relations to the object, based on a mode of apprehending and experiencing the object (Segal, 1979). The alterations and changes in those relations ensure the evolution of both the object and the ego. Furthermore, the object is not pre-given by external reality: it is itself a result and a construction ensuing from the subject's relation to it, as will become abundantly clear.

The paranoid-schizoid and depressive positions are differentiated from each other on the basis of the type of anxiety, ego-defences and object-relations that characterise them. They appear and evolve during the first year of life but are not limited to that period only. They reappear later during childhood and in adult pathological and normal states (Pontalis, 1968).

APPROXIMATE AGE PERIOD	DEVELOPMENTAL PHASE	SUB-STAGES	DRIVE CONSTITUTION	AIM	OBJECT EVOLUTION	ANXIETIES AND DEFENCES	SUPER-EGO DEVELOPMENT
0-4/5 months	Oral pre-ambivalent	Oral sucking stage	Oral libido  Possible anal sadism if frustration excessive		Good breast	not specified ?	not specified
4/5 months onwards	ORAL  ambivalent	Oral cannibalistic stage	Oral libido  Oral sadism	Incorporation  Scooping out, sucking out, destructive amihilation	'GOOD' BREAST  'BAD' BREAST	PERSECUTORY OR PARANOID ANXIETY	Harsh super-ego: persecutory initially
Meaning		MAXIMAL SADISM  EARLY GENIPIUS COMPLEX	Anal sadism  Muscular sadism  Epistemophilic urge  Genital libido	Flooding, drowning, burning  destructive attack, poisoning  taking complete control of  knowing what is inside  giving, repairing	MOTHER'S BODY with multiple contents (milk, urine, faeces, babies)  penis  'Combined parental figure' in a state of mutual satisfaction	INTROJECTION PROJECTION RADICAL SPLITTING OMNIPOTENT DENIAL WISH FULFILLING HALLUCINATION IDEALISATION OMNIPOTENT REPARATION	Bad breast  Bad penis
End of first year					Whole mother, whole father		to 3rd year of life

CHART I

APPROXIMATE AGE PERIOD	DEVELOPMENTAL PHASE	POSITION	DRIVE CONSTITUTION	AIM	OBJECT-RELATION	ANXIETIES AND DEFENCES	SUPER-EGO DEVELOPMENT
0-3/4 months	ORAL	PARANOID-SCHIZOID	Oral libidinal Oral cannibalism Urethral Anal Muscular trends	Incorporation Possession Greedy, destructive attacks - scooping out Flooding, drowning, burning, poisoning	IDEAL BREAST PERSECUTORY BREAST MOTHER'S BODY WITH GOOD AND BAD SUBSTANCES INSIDE FATHER'S PENIS	PERSECUTORY ANXIETY SCHIZOID MECHANISMS (a) Radical splitting Omnipotent denial Idealisation (b) Projective identification (c) Introjection and projection (d) Introjection of 'good' object	Super-ego Introjects beginning - harsh and excessively punitive internal objects 'Bad, devouring breast' 'Bad penis'
4 months onwards	ORAL	DEPRESSIVE POSITION	Same as above Intensification of genital trends	The above with reparative urges more prominent	COMBINED PARENTAL COUPLE Damaged maternal and paternal object	Above continue Depressive anxiety - new psychological reality with new feelings: ambivalence fear of loss guilt mourning, pining dependence. <u>MANIC DEFENCES</u> Omnipotent control Splitting - denial Omnipotent reparation	Bad, objects Good and bad part-objects and damaged whole-objects
6 months		Conflictual pitch Oedipus Complex positive negative			Slow evolution to Whole maternal & paternal object as increasingly separate	Reparation proper	More benevolent esp. as reparation increases
End of 1st year					To genital Oedipal objects		

CHART I I

In Kleinian theory, object relations start from the very beginning of neo-natal life. At birth, a minimal degree of ego-organization capable of relating to part-objects is assumed (Segal, 1979). However, both the ego and the early part-object are characterised by their marked lack of integration. It can be said that the originality of M. Klein's work consists in her attempt to map out the complex and tortuous path that leads from part-object relations to whole-object relations. Along that path lies the major developmental task of mastering psychotic anxieties and their disintegrative effects (Heimann and Isaacs, 1952), and it is one of the hallmarks of M. Klein's work that psychotic processes have become more integrated within the human experience

#### 4.2.2 Drive dualism: The life and death instinct.

In her early work Klein links the appearance of drive dualism with the advent of oral cannibalism (Chart I), that is, approximately around the middle of the first year. Still under the influence of Abraham's theory of psycho-sexual development (Abraham, 1924), Klein considered the first oral sucking stage as dominated by the life instinct and therefore as a pre-ambivalent stage (Klein, 1932). In her later work she holds the view that instinctual dualism is operative right from birth, in the form of oral libido and oral destructiveness (Klein, 1948). Klein is the only psychoanalytic theoretician, after Freud, to have made full theoretical and clinical usage of this concept (Laplanche and Pontalis, 1973). It is worthwhile devoting some attention to the concept of the death drive so as to understand the particular usage Klein makes of this originally Freudian concept.

For Freud, the death instinct works destructively against the organism as a tendency towards disintegration. Freud conceived of its vicissitudes in three ways: "The activity of the dangerous death instincts within the individual organism is dealt with in various ways; in part they are rendered harmless by being fixed with the erotic component, in part they are diverted towards the external world in the form of aggression, whilst for the most part they undoubtedly continue their inner work unhindered" (Freud, 1923 : 79).

M. Klein accepts the postulate of the inner workings of the death drive. However, diverging from Freud (Klein, 1948) she asserts that the ego at birth, under the sway of the death drive, experiences anxiety about disintegration and annihilation: "At the beginning of post-natal life the infant experiences anxiety from internal and external sources. I have for many years held the view that the working of the death instinct within gives rise to the fear of annihilation and that this is the primary cause of persecutory anxiety" (Klein, 1952 : 61). The prototype of anxiety is thus annihilatory or persecutory. However, although pre-given, the drive is never grasped in its pure form but rather through its ideational representative (Freud, 1915(a)). In Kleinian theory, it is the mechanism of deflection or projection outwards which leads to the death drive acquiring its first ideational representative in the form of the 'bad' breast (Section 4.2.3). Similarly, oral libido acquires its first representative in the form of the 'good' breast.

Thus, in Klein's later work, the drive dualism which operates from the very beginning colours the first object relation, as a result of which the first psychological object, the breast, is experienced in its split form. This early split, and persecutory anxiety, characterise

the paranoid-schizoid position.

#### 4.2.3 The internal, external and real object - psychical reality

For sake of clarity it is useful to distinguish between three different concepts of object which pervade Klein's thought. Firstly, the real object or the object of external reality (breast, penis, mother, father), as it exists independently of the infant. The infant's relation to the real object, however, is strongly coloured by its phantasy activity (Isaacs, 1952). As a consequence Klein uses the concept of the external object so as to mark the discrepancy which exists between the real object and the external object. The external object is a phantasy-object: it evolves as a result of the combined operation of the defence-mechanisms of projection and introjection (Heimann, 1952).

On the other hand, the external object must be contrasted with the internal object. "Since instinctual development begins under oral primacy, and experiences set their stamp on all sensations and experiences, so that at the beginning all experiences include oral elements: mouthing and swallowing and spitting (introjecting and projection) recur ... Beginning with the introjection of the breast, the infant proceeds to introject all his objects" (Heimann, 1952 : 127). The external object, itself a result of projection, is introjected and set up within the ego as an internal object. The internal object is itself re-projected, so that the external object acquires some of the qualities of the internal object as well. Thus through a complex series of projections, introjections, re-projections and re-introjections, a psychical world made up of internal and external objects is gradually built up.

Both the internal and external objects are psychical objects (Heimann, 1952): they have psychical reality as compared to material reality. The above distinction is fundamental in psychoanalytic theory. Freud was the first to emphatically mark the distinction (Freud, 1916-17(a), 1915(a) which Kleinians adopt and maintain completely (Heimann, 1952; Isaacs, 1952). Put simply, psychical reality is the object of study of psychoanalysis. It involves unconscious desire and its associated phantasies (Laplanche and Pontalis, 1973). In a most scintillating passage of the observed primal phantasies of neurotic patients Freud writes: "Yet this is the only correct attitude to adopt towards these mental productions. They too possess a reality of a sort. It remains a fact that the patient has created these phantasies for himself, and this is of scarcely less importance for his neurosis than if he had really experienced what the phantasies contain. The phantasies possess psychical as contrasted with material reality, and we gradually learn to understand that in the world of neuroses it is psychical reality which is the decisive kind" (Freud, 1916-17(a) : 415). Psychical reality, unconscious desire and phantasy and the inner world of the person are all interrelated concepts. In true Freudian spirit, Klein follows the setting up of psychical reality from earliest infancy onwards, and shows that human development cannot be understood if psychical reality is not taken into account. This stance does not entail the negation of the influential role of the environment (the real object) but it prevents the 'prejudice in favour of material reality' (Isaacs, 1952).

The internal and external objects are psychical objects that mutually influence each other in a thoroughly dialectical relationship. But the terms internal and external imply that psychical reality

is founded on a basic dichotomy between the 'in' and the 'out'. Freud, in his important paper on 'Negation' writes: "Expressed in the language of the oldest, that is of the oral instinctual impulses, the alternative runs thus: 'I should like to take it into me and keep that out of me'. That is to say, it is to be either inside me or outside me" (Freud, 1925 (b) : 183).

The mechanisms of projection and introjection, operative from the very beginning, constitute the principle whereby the basic dichotomy of psychological reality is founded. Oral libido acquires its first psychological representative: the internal and external 'good' breast. Oral cannibalism (destructiveness, sadism) acquires its first psychological representative: the internal and external 'bad' breast. Psychological reality to start with is founded on two basic dichotomies: the 'in' and the 'out', the 'good' and the 'bad' (Laplanche and Pontalis, 1973).

#### 4.3 The paranoid-schizoid position

The paranoid-schizoid position is characterised by a type of anxiety: persecutory anxiety, against which the ego protects itself by using the schizoid mode of defence. Schizoid defences can be separated into two sub-categories: omnipotent splitting (Segal, 1964) and denial, and projective identification (Segal, 1964). The paranoid-schizoid position starts from birth onwards, up to approximately three to four months of age, when the object-relation is considerably modified and the depressive position is inaugurated.

#### 4.3.1 The 'good' and 'bad' breast

The first object of the child is a part-object, not simply because it is a part of the whole person (mother) but also because it is split into its 'good' and 'bad' aspects (Segal, 1979).

Klein postulates the following model so as to explain the formation of this initial split. In periods of freedom from hunger and tension, that is, in periods of no privation or frustration, there exists an optimal balance between libidinal and aggressive drive components. However, owing to privations from internal or external sources, e.g. feelings of hunger, internal discomfort, and absences of the mother, which are all inevitable ingredients of development, the optimal balance is altered and this gives rise to the emotion of greed. Greed, which is first and foremost of an oral nature, reinforces the aggressive impulses so that the object is attacked at the level of phantasy (Klein, 1952). That part of the ego which feels destructive, greedy and cannibalistic is projected into the breast, as a result of which the breast acquires the phantasy colouring of the id. The hated breast becomes a hating, persecutory breast. The death instinct thus acquires its first psychological representative: the 'bad' breast, the external persecutor. Part of the aggression stemming from the death drive is deflected outwards in the form of aggressive phantasy attacks onto the persecutor (Segal, 1964). The more the aggressive attacks, the more the persecutory anxiety, and the more the persecutory anxiety, the more the aggressive attacks against the persecutor.

In similar fashion, the breast that gratifies and satiates, the breast which provides 'good' experience, becomes, by projection

of the oral love impulses, the 'ideal' breast, the external good object which should fulfill the greedy desire for unlimited, immediate and everlasting gratification: "Thus feelings arise about a perfect and inexhaustible breast, always available, always gratifying" (Klein, 1952 : 64).

Both the persecutory and ideal breast are introjected and become established inside the ego. Those internal objects in their split form constitute the beginnings of the early super-ego. According to Klein, the super-ego develops right from the beginning, and owing to its close relationship with the id impulses is extremely harsh and persecutory to start with (Klein, 1948). Although it is difficult, in Kleinian theory, to distinguish between those introjects which go to make up the ego and those which go to make up the super-ego (Heimann, 1952), the notion of the early super-ego formation will become particularly relevant for Klein's theory of obsessional neurosis (Chapter 5). Thus, in this way, out of chaos a primitive organisation emerges: a split-off breast and a split-off ego, in their respective benevolent and persecutory aspects. Persecutory anxiety dominates. The ego makes use of schizoid defence mechanisms to modify the early fear of annihilation which is disintegrative.

#### 4.3.2 Persecutory anxiety, splitting, idealisation and omnipotent denial of psychological reality.

The early ego is weak, and yet it is characteristic of the emotions of the young infant that they are of an extreme and powerful nature (Klein, 1952). Persecutory anxiety felt as the dread of total annihilation, brings about radical splitting, and the idealisation of the 'good' breast: "In so far as idealisation is derived from the

need to be protected from persecutory objects, it is a method of defence against anxiety" (Klein, 1952 : 64).

Idealisation as a defence comprises a group of processes which operate simultaneously (Klein, 1946, 1952). When persecutory anxiety increases, as a result of frustration and greedy phantasy attacks, the ego hallucinates the inexhaustible, perfect, and ideal breast through the process of wish-fulfilling hallucination. The concept of wish-fulfilling hallucinations is originally Freudian (Freud, 1911). In Kleinian theory, however, it becomes closely linked with the concept of introjection and unconscious phantasy (Isaacs, 1952). Under the fear of annihilation the early ego wishes and hallucinates, that is wish-fulfills, the ideal breast. Thus for a while it assumes omnipotent control and possession of both the external and internal perfect breast. The wish to have the breast fulfills itself omnipotently in the hallucinatory experience of incorporating the breast, of having the internal perfect breast: "We must assume that the incorporation of the breast is bound up with the earliest forms of the phantasy-life" (Isaacs, 1952 : 86). The omnipotent possession of the ideal breast entails the omnipotent denial of psychical reality: frustration, phantasy-attacks on the object, the ensuing retaliation from internal and external persecutors and annihilatory anxiety are all felt to have gone out of existence, to have been annihilated. Thereby, gratification and relief from persecutory anxiety is obtained (Klein, 1946, 1952).

The omnipotent denial of the persecutory situation entails not only the annihilation of persecutory objects, but it is an object-relation which suffers this fate, and "therefore part of the ego, from which the feelings towards the object emanate, is denied and

and annihilated as well" (Klein, 1946 : 299). Herein lies the paradox of radical splitting as a mode of defence: in attempting to ward off the disintegrative effect of persecutory anxiety, the ego splits the object and its relation to it in an active way, and this implies active splitting of the ego itself. Klein makes an explicit connection between the above defence mechanism and the schizophrenic feeling that his ego is in bits, fragmented, disintegrated (Klein, 1946).

#### 4.3.3 Projective identification

Before dealing with the concept of projective identification it is useful to make the following chronological point. In early Klein (Chart I) the relation to the 'good' breast dominates the first 6 months of life. In the second part of the first year of life the oral cannibalistic urges and trends initiate the phase of maximal sadism (Klein, 1932). The concept of maximal sadism entails an approach to psycho-sexual development which diverges from the Freudian conception. Although, according to Klein, the oral phase dominates the first year of life, other drive trends make their appearance during the phase of maximal sadism. Thus urethral, anal, muscular sadistic, and genital trends feature during the phase of maximal sadism (Klein, 1932; Segal, 1979). Furthermore, during that phase the first part-object: the breast, gradually gives way to the evolution of a new object: that of the mother's body, a transition object of sorts, on the path to whole object-relations. The relation to the mother's body becomes psychically dominant in other words. In her early work Klein describes the phase of maximal sadism as follows: "Every other vehicle of sadistic attack that the child employs, such as anal

or muscular sadism, is in the first instance levelled against its mother's breast, but it is soon directed to the inside of her body, which thus becomes the target of sadistic attacks coming from every source at once and raised to the highest pitch of intensity. In early analysis these destructive desires of the small child constantly alternate between anal-sadistic desires, desires to devour its mother's body and desires to wet it; but their primal aim of eating up and destroying her breast is always discernible in them" (Klein, 1932 : 186).

In later Klein (Chart II) the concept of maximal sadism is abandoned but the object-relation to the mother's body which comprises oral, urethral, anal, and later, genital trends is initiated during the paranoid-schizoid position (Klein, 1946 , 1952). Thus a great deal of what Klein articulated about this object-relation in her earlier work retains its value in her later work, but the process has become clarified especially with the formal articulation of the concept of projective identification (Segal, 1979).

Projective identification evolves out of primitive projection and is inseparable from it. Thus if by projection it is generally understood that the impulse is done away with and projected onto the object, in projective identification it is not the impulse only which is projected but parts of the self such as the infant's mouth, bodily products such as urine and faeces and the penis, are projected into the object. Not only part of the self but "the whole self - felt to be 'bad' self - enters the mother's body and takes control of it" (Klein, 1952 : 68). Thus the object becomes a representative of the ego after the ego has taken possession by projection of the external object. The mother's body can become identified with all the bad parts of the self projected into it. As a consequence "when projection is

dominated by persecutory fear, the object into whom badness has been projected becomes the persecutor par excellence, because it has been endowed with all the bad qualities of the subject" (Klein, 1952 : 69). The re-introjection of this object reinforces acutely the fear of internal and external persecutors.

The aims of projective identification are manifold: getting rid of an unwanted part of the self, a greedy possession and scooping out of the object, and control of the object (Segal, 1979). This mechanism, although an integral part of normal development, is evident in the phenomenology of psychosis: a delusion of persecution is a classical illustration of projective identification of the object with bad parts of the self. It is not only the bad parts of the self which are projectively identified with the object, but also the good parts (Segal, 1964). Projective identification of the good parts of the self may lead to excessive idealisation of the object and extreme devaluation of the self. When bad parts are projected, the object becomes a dreaded persecutor; when good parts are projected, there is a particular schizoid dependence on the object: it has to be controlled because the loss of the object would entail the loss of a part of oneself. Simultaneously, there is a fear of being completely controlled since the object contains a valued part of the self (Segal, 1964). Object-relations based on the schizoid mechanisms of projective identification are fraught with idealisation on the one hand and persecution on the other, leading to such a conflictual situation that the person might decide to cut himself off from all object-relationships. This mechanism throws light onto the erroneous belief that psychotics and schizoid personalities do not develop a transference relationship. This belief has now been exposed for the truth it eludes: the intense persecutory fear, idealisation and fear of subjugation resulting from love relation-

ships, of which transference is a special one and from which narcissistic retreat is a refuge.

When persecutory anxiety in the paranoid-schizoid position is excessive and schizoid defences are mobilised, psychical structures are established, which underlie the schizophrenic group of illnesses, the schizoid personality, and the paranoid and schizoid features of infantile or adult neuroses (Klein, 1946; Rosenfeld, 1947; Segal, 1964, 1979).

Persecutory anxiety and the schizoid modes of defence are divisive and disintegrative. What then impels the ego to integrate and overcome the early splits? One dominant mechanism counteracts this divisive tendency: "The introjection of a good object, which itself stimulates the projection of good feelings outwards and itself by re-introjection strengthens the feeling of possessing a good internal object" (Klein, 1952 : 69). Broadly speaking, M. Klein places strong emphasis on feelings of love, libidinal impulses - the expressions of the life instinct - in enhancing integration and strengthening the ego in its precarious battle against aggression, persecutory anxiety - the expressions of the death drive - and their disintegrative effects. The ability to trust the good object (external and internal) leads to a decreased fear of persecutors (external and internal). In this general principle of human development Klein echoes Freud's contentions in his famous last work : " The aim of Eros is to establish even greater unities and to preserve them thus - in short, to bind together; the aim of the destructive instinct is, on the contrary, to undo connections and to destroy things" (Freud, 1940).

The paranoid-schizoid position comprises both integrative and disintegrative tendencies. Klein stresses that alongside the radical

splitting which accompanies schizoid mechanisms, there are "good grounds to assume that even during the first three or four months of life the good and the bad object are not wholly distinct from each other in the infant's mind" (Klein, 1952 : 63). In addition, towards the fourth month of life, consciousness, intellectual capacities, and the relation to the external world are steadily developing. The infant's sexual organization is progressing, urethral, anal and genital trends increase in strength. As a result, the emotional life of the infant and his range of phantasies are greatly enriched and enhanced by such changes (Klein, 1952; Segal, 1964). The child's relatively more integrated ego can start to synthesize both libidinal and destructive impulses in its relation to the same object. A new mode of object-relation, new anxieties and different modes of defence are called forth in the face of the increasingly poignant psychical reality characterised by ambivalence: the infant enters the depressive position.

#### 4.4 The Depressive Position

##### 4.4.1 Ambivalence and the whole object

In Klein's later work, the depressive position starts at approximately three to four months of life and reaches a pitch of intensity around the middle of the first year of life (Klein, 1935, 1940, 1945, 1952), when the mother is perceived, and related to, as a whole person.

Strictly speaking, it makes sense to refer to the paranoid-schizoid position as a pre-ambivalent position. Although in later Klein the

the death drive is operative from the beginning and thus the pre-ambivalent sucking stage is abandoned (Chart II), the radical splitting mechanisms that operate during the paranoid-schizoid position aim at keeping the 'good' and 'bad' object widely apart, and therefore given the logic of object-relation theory, the love and destructive impulses of the subject are equally kept separate. Schizoid mechanisms preclude ambivalence, since ambivalence entails the emergence of both love and destructive impulses towards the same object (Segal, 1979). It is only once the ego and the object are more integrated, and this degree of integration is the essential criterion for a relatively successful negotiation of the paranoid-schizoid position, that the specific conflicts around ambivalence emerge. Those particular conflicts herald the depressive position. In the depressive position the object-relation is characterised by a relation to a whole object, not only in the sense that the mother is increasingly related to as a whole person, in contrast to the part-object breast or mother's body, but equally in the sense that it is the same object who is at times 'good' and at times 'bad', present or absent, and loved or hated (Segal, 1964). This new turn in development has wide implications and opens up a new world of experience.

#### 4.4.2 Depressive anxiety

In the depressive position introjective processes increase and projective processes diminish: "... the dread lest the good object should be expelled along with the bad causes the mechanisms of expulsion and projection to lose value. We know that, at this stage, the ego makes a greater use of introjection of the good object as a

mechanism of defence" (Klein, 1934 : 265). ] As a consequence of the relative decrease in schizoid mechanisms, the power of the destructive impulses and persecutory anxiety is equally attenuated (Segal, 1964). However, destructive impulses are now felt to be a great danger to the loved object, and the dominant anxiety is no longer that of persecution or annihilation but rather that of losing the good, whole object. The anxiety of losing the object intensifies greed which as an emotion "is felt to endanger the loved internal and external object" (Klein, 1952 : 73).

The anxiety of losing the good, whole object which characterises the depressive position is called depressive anxiety. Thus the infant is now exposed to a new set of feelings little known in the paranoid-schizoid position. Those are feelings of mourning and pining for the good object, felt to be lost or destroyed. Guilt, as a characteristic depressive experience, results from the sense that the good object is destroyed or lost as a result of the infant's own destructive urges (Klein, 1952). At the height of depressive despair feelings of persecution are equally felt, because the bad feelings are projected into internal persecutors, and partial regression to the paranoid-schizoid position occurs (Segal, 1964; Klein, 1935). In her paper on the psychogenesis of manic-depressive states M. Klein shows in great detail the link between psychotic depression and paranoid anxieties (Klein, 1935). Thus there is no exclusive delineation between the paranoid-schizoid and the depressive positions, and elements of the more primitive anxiety-situation remain. However, a new relation to the object is under way, and new feelings and modes of defence characterise the depressive position.

The task of the depressive position is the re-establishment of the disrupted inner world, or the internal good objects, felt to be damaged or lost. M. Klein has emphatically stressed that the task in mourning and depression is not only to decathect the lost object (Freud, 1915) but especially that of re-establishing the damaged internal object: "A successful reinstating of the external love object which is being mourned, and whose introjection is intensified through the process of mourning, implies that the loved internal objects are restored and regained. Therefore the testing of reality characteristic of the process of mourning is not only the means of renewing the links to the external world but of re-establishing the disrupted inner world" (Klein, 1952 : 77).

Two types of ego defences are mobilised in the struggle to ward off depressive anxiety and to secure good internal and external objects. On the one hand, a group of defences which Klein has named: the manic defences. On the other hand, reparation (Klein, 1935, 1940, 1952). The above delineation invites commentary. Reparation, in so far as it is omnipotent or manic, is an intrinsic part of the manic defences, since it operates by denial of psychological reality. However, reparation proper is non-defensive and a vitally important means of combating depressive anxiety and the associated feelings. It is proposed, however, that reparation, manic and non-manic, be treated together so as to establish the difference more markedly.

#### 4.4.3 The manic defences

The manic defences are an intrinsic part of development, but can become pathological if, as a result of excessive depressive

anxiety, they constitute fixation points for later regressions. As part of normal development they fulfill the important function of protecting the ego against depressive despair, and thus promote further integration by giving way to reparation proper (Segal, 1964).

Depressive anxiety is characterised by a new set of feelings: feelings of dependence on the object which is increasingly perceived as independent; ambivalence which leads to fear of loss, mourning and pining; and guilt. It is against those new feelings which were not part of the infant's psychical reality in the paranoid-schizoid position that the manic defences are directed. The manic defences comprise omnipotent denial of psychical reality, control, radical splitting and omnipotent reparation (Klein, 1935, 1940, 1952; Segal, 1964). The above defences operate simultaneously.

Feelings of love and dependence on the object are omnipotently denied, obviated and reversed: "The ego even denies that it loves the object at all. The result might be a lasting stifling of love and a turning away from the primary objects and an increase in persecutory anxiety i.e. regression to the paranoid-schizoid position" (Klein, 1952 : 73). The above form of denial is extreme. Usually manic defences aim at denying the existence of valued internal objects and thus of feelings of dependence, ambivalence and guilt towards the internal object (Segal, 1979).

The strong ambivalence felt towards the object is defended against by a renewal of splitting of the object and of the ego. However, although earlier schizoid modes of splitting are still operative in the depressive-position (Klein, 1940) the type of splitting which characterises

the manic defences is significantly different: "... the ego now divides the complete object into an uninjured live object and an endangered one (perhaps dead or dying)" (Klein, 1952 : 74). Suddenly, the ego is felt to contain dead or dying objects, a feature which is prominent in the mental state of severely depressed patients and more commonly known as nihilistic delusions (Klein, 1935; Freedman, Kaplan and Sadock, 1976). Or, it is felt to be triumphantly alive as in a manic episode during which depressive anxiety is denied.

In the same vein, denial of psychological reality is maintained by a particular relation to the object which features omnipotent control, triumph and contempt (Klein, 1940; Segal, 1964). Control is a way of denying dependence, and yet of compelling the object to fulfil a need for dependence, since it is completely controlled. Triumph entails the omnipotent denial of depressive feelings of valuing, losing, caring, and pining. Simultaneously, triumph expresses the destructiveness towards the object, destructiveness which initially led to guilt and fear of loss, and against which the manic defences are invoked (Klein, 1940). Contempt for the object is a direct way of devaluing the object, and is thus a defence against the experience of loss and guilt: "An object of contempt is not an object worthy of guilt, and the contempt that is experienced in relation to such an object becomes a justification for further attacks on it" (Segal, 1964 : 71).

#### 4.4.4 Omnipotent reparation and reparation proper

Reparation is a vitally important mechanism whereby the infant seeks to repair the effect his destructive phantasies have had on his love-object. The phantasised reparation of the external and internal

maternal object eventually permits the overcoming of the depressive position by guaranteeing the ego a stable identification with the beneficial object (Laplanche and Pontalis, 1973).

Klein considers the reparative drive as a most important expression of the libidinal or life instinct, and through reparation, love comes more sharply into conflict with hate (Klein, 1937). Reparation both controls destructiveness, and restores the damage done in phantasy. Through the recovery of the lost or damaged object the infant develops an increased trust in his own love and his own capacity to restore his internal object and to retain it as good. This mechanism leads to the ability of experiencing deprivation, absences and frustrations without being overwhelmed by hatred. The child's own hatred also becomes less frightening, since he believes that his love can restore what his hatred has destroyed (Segal, 1964). This creative aspect of reparation is a fundamental psychological force and as such is an intrinsic non-defensive part of the depressive position.

However, reparation is initially employed in an omnipotent way, and as such is part of the manic defences. Omnipotent or manic reparation aims at a radical denial of depressive anxiety. The phantasy of omnipotent reparation can be expressed as follows: "My mother is disappearing, she may never return, she is suffering, she is dead. No, this can't be, for I can revive her" (Klein, 1952 : 75). Thus the destructive attacks on the maternal object, omnipotently carried out, and hence leading to feelings of persecution, loss, pining and so on are omnipotently cancelled by the magical revival, at the level of phantasy, of the injured object. Feelings of guilt and loss, that is psychological reality, are omnipotently denied

An essential feature of manic reparation is that it has to be done without acknowledgement of guilt, and therefore under special conditions. Segal points out that manic reparation is usually carried out not directly in relation to primary objects, but in relation to more remote objects. Such objects are not experienced as having been damaged by oneself since this would be tantamount to the acknowledgement of ambivalence. Furthermore, the objects are often felt as inferior, dependent, and at depth contemptible, since feelings of love for the object or objects being repaired would entail the return of depressive feelings (Segal, 1964).

Manic reparation betrays the underlying destructive urges which it seeks to deny. The concomittant guilt which it seeks to alleviate is in fact not relieved, and as a defence it brings no lasting satisfaction. The objects thus repaired are "unconsciously, and sometimes consciously, treated with hatred and contempt and are invariably felt to be ungrateful and, at least unconsciously, are dreaded as potential persecutors" (Segal, 1964 : 83).

#### 4.5 The early Oedipus Complex

It would be incomplete to review the psychotic anxieties that pervade the first year of life without including the early Oedipus Complex. An essential aspect of the depressive position is that the Oedipus Complex starts to develop during that phase. As the mother becomes increasingly perceived and related to as a whole object the child's perception of the world undergoes important modifications: the mother is perceived as having a relationship with father as an independent person and this gives rise to a new set of feelings and

conflicts (Klein, 1945).

#### 4.5.1 Klein's divergence from Freud

In her early writings (Klein, 1932), M. Klein had already departed significantly from Freud's view on the Oedipus Complex. Her work with young children had led her to postulate that prior forms of the Oedipus Complex are in evidence in very young children, and that the positive Oedipus Complex of the phallic phase as described by Freud (Freud, 1910, 1923, 1924, 1925) is a late development based on those primitive forms.

In Klein's earlier and later work (Chart I and II) the Oedipus Complex appears around the middle of the first year, that is, when the depressive position is at its height. The following question can therefore be asked: Is it legitimate to use the term Oedipus Complex, a term which refers to a psychical configuration so closely associated with the phallic libidinal organisation, at a developmental phase dominated by the oral organisation? The answer is dependent on the particular view of psycho-sexual development which Kleinians adhere to: namely that during oral phase dominance, urethral, anal and genital trends are present (Heimann and Isaacs, 1952; Klein, 1932).

Heimann expresses the Kleinian position as follows: "At the beginning the oral impulses lead in this orchestra of polymorphous urges, and, together with the urethral and anal zones, overshadow the genital for a time, so that genital excitations are in part linked with pre-genital phantasies. In the second part of the first year, however, genital strivings gain in strength ..." (Heimann, 1951 : 27).

The Oedipus Complex is born at a time when part-object relations are still dominant, but Klein would strongly disagree with the view that the early Oedipus Complex is merely a precursor of the 'true form' which is to follow. In her opinion, it is the beginning of the Oedipal drama proper: "I consider that early genital impulses and phantasies, although they set in during the phase dominated by sadism, constitute, in children of both sexes, the early stage of the Oedipus Complex because they satisfy the accepted criteria for it" (Klein, 1932 : 191). In the above quotation Klein still adheres to the view that the Oedipus Complex was born in the phase of maximal sadism, (Chart I) but as already explained, the theory of maximal sadism was abandoned with the formulation of the concept of the depressive position (Section 4.3.3). Furthermore, Kleinians argue that the particular anxieties occasioned by the early Oedipus Complex, and their negotiation, profoundly affect later genital outcomes (Heimann and Isaacs, 1952).

#### 4.5.2 The early Oedipus Complex and the combined parental figure

The evolution from part-object relations to whole object-relations is marked by a series of transitional phantasy-objects which M. Klein has described in detail in her early work (Klein, 1932). After the breast, another object acquires psychological significance: that of the mother's body with the father's penis (or penises) inside it. Like the breast, this psychological object is both an object of powerful libidinal desires, and of envy and hatred. In its idealised form the mother's body is the container of everything desirable: breast, milk, valuable magic faeces, babies and penises (Klein, 1932, 1945, 1952).

During the paranoid-schizoid position the "infant's urge to enter his mother's body and take possession of its contents is predominantly of an oral and anal nature" (Klein, 1952 : 78). In her early article on the Oedipus Complex and super-ego formation (Klein, 1932), Klein gives a detailed description of the different sadistic phantasies of children in relation to the mother's body. Urethral sadism is manifested in phantasies of destroying by flooding, drowning, soaking, burning by means of enormous quantities of urine which acquire the symbolic significance of a dissolving and corroding liquid, a secret and insidious prison (Klein, 1932 : 191). Similarly, anal products become instruments of direct assault and substances of an explosive anal poisonous kind. These omnipotent phantasies are an intrinsic part of the schizoid defence of omnipotent control. Through projective identification the mother's body becomes a persecutory object, external and internal.

Those oral, urethral and anal urges are still active during the depressive position, but now genital desires become more intense (Heimann and Isaacs, 1952). When genital desires increase, the infant's libidinal and destructive urges are directed more towards the father's penis, which the infant feels the mother's body contains (Klein, 1952). The Oedipus Complex is inaugurated when the father's penis becomes a meaningful imago, an object of both intense libidinal and destructive urges. Erna, an obsessional patient (Klein, 1932), played many games symbolising the eating of her mother's breast and her father's penis. Rita, Klein's youngest patient (Klein, 1932), developed an elaborate bedtime ritual which protected against the persecutory anxiety of being attacked by a mouse or a 'Butzen' at night. The 'Butzen' which would bite off her own 'Butzen'

symbolised the devouring part-object penis in its persecutory, split form (Segal, 1979).

The early Oedipal triangular constellation is a combined figure which, according to Klein, gives rise to severe psychotic anxieties: "Thus the penis inside the mother represents a combination of mother and father in one person, and this combination is regarded as a particularly terrifying and threatening one" (Klein, 1932 : 190). Against such psychotic anxieties of both a persecutory and depressive kind, the schizoid and manic defences and the reparative urges are mobilised. However, the early Oedipus Complex is not only disintegrative in its effects. It simultaneously constitutes a significant advance in the broadening of object-relations, since a new psychical-object, the father's penis, has now become a meaningful imago to the infant. As a consequence, the frustrations and anxieties encountered in relation to the maternal object become transferred onto the father's penis (Klein, 1945). This distribution of desire, aggression, and anxiety over a broader range of objects enhances the chances of acceding to more integrated object-relations, which is the developmental task of the depressive position (Klein, 1952).

The early Oedipal figure gradually gives way to what Klein calls the combined parental figure, as father and mother become perceived as whole separate objects (Segal, 1979). The combined parental figure is a phantasy creation of the infant and, in it, both parents in intercourse are combined into one figure (Klein, 1932). Klein assumes that the infant has an unconscious 'knowledge' of the parents in intercourse, that is of both parents in a state of mutual gratification. The type of gratification or exchange (oral, anal and genital) that colours the phantasy object is fixed by the particular stage of psycho-sexual

development. For Klein, envy is inherent in oral greed and is first directed towards the feeding breast. When the Oedipal situation arises, jealousy is added to the more primary envy. Thus frustrations and deprivations which are inevitable are 'understood' by the infant according to the logic of desire which Klein succinctly expresses in the following terms: "When he is frustrated, father or mother enjoys the desired object of which he is deprived - mother's breast, father's penis - and enjoys it constantly. It is characteristic of the young infant's intense emotion and greed that he should attribute to the parents a constant state of mutual gratification of an oral, anal and genital nature" (Klein, 1952 : 79). The combined parental figure in a state of mutual intercourse is a terrifying object because of the jealousy, rivalry, and hatred which it inevitably stirs up.

The parallel between the combined parental figure and the Freudian notion of the 'primal scene' can be drawn. "Amongst the store of phantasies of all neurotics, and probably of all human beings, this scene is seldom absent" (Freud, 1915). Freud has depicted the primal scene phantasy as having certain key characteristics. It is always understood as an act of aggression by the father, a sadistic coitus; it provides an admixture of sexual excitation and anxiety in the child; and it is interpreted as anal coitus, within the framework of the theory of birth (Freud, 1908). Segal (1964) points out that the parental intercourse is perceived as sadistic because the child experiences this phantasy with such hatred and envy. As a result of projective identification the object becomes a hateful one: mother attacking father, father attacking mother and both attacking him. This terrifying Oedipal image is at the basis of the many-headed and many-legged monster which enters into the child's nightmares and fears

(Segal, 1979).

Since introjection is very active during the depressive position, those attacked and destroyed parents are felt by the infant as part of his internal world. "In the depressive position the infant has not only to deal with a destroyed internal breast and mother, but also with the internal destroyed parental couple of the early Oedipal situation" (Segal, 1964 : 91).

#### 4.5.3 The little boy's and little girl's Oedipus Complex

Within the context of such a thesis only the briefest reference will be made to the intricate dynamics of the early Oedipus Complex.

According to Klein the little girl and boy start with the negative (inverted) and positive form of the Oedipus Complex (Klein, 1932, 1946). For the little boy, the frustrations and anxieties encountered at the breast and with mother leads to the father's penis becoming a substitute object of desire (Klein, 1946). The wish to incorporate the penis, initially orally, and later anally and genitally (in the unconscious the anus and phallus, at the phantasy level, can be treated as receptive organs) represent the root of the male's homosexual or feminine position (Klein, 1946). In this position the little boy is his mother's rival. The introjection of the 'good' penis is, however, important in that it equally reinforces his masculine desires for his mother. Those primary libidinal desires for the maternal object are secondarily reinforced by the reparative urges which play such an important role in modifying depressive anxiety. The belief in the good procreative penis contributes a great deal to the boy's heterosexual

position. In his positive Oedipal position, the paternal object is the rival and as a result of projective identification the father's penis can become a persecutory object. Klein sees the castration anxiety typical of the phallic phase as a later development of the persecutory relation to the father's penis (Heimann, 1951 : 30).

The little girl's Oedipus Complex is in many respects similar to that of the boy. She oscillates between heterosexual and homosexual positions. Kleinians, in contradistinction to Freudians (Mitchell, 1974), maintain that the little girl experiences vaginal sensations and the associated phantasies of a feminine character during the early Oedipus Complex. The little girl wishes to incorporate and receive the father's penis (Klein, 1946). Later on, this wish is transformed into that of receiving a child from him. In this positive early Oedipus Complex the infant girl's mother is the rival. The phantasy attacks on mother's body and its contents intensifies her fear that the persecutory mother will attack her and rob her body of its good contents (Klein, 1946). This fear of aphanisis (Jones, 1948) is, according to Klein, the equivalent of castration anxiety in the little girl (Segal, 1979). Such frustrations and anxieties inherent in her positive Oedipus Complex reinforce her homosexual trends and the girl phantasises the possession of a penis. The girl's inverted Oedipus Complex, according to Kleinians, covers in some measure the frustrated desire to take her mother's place with the father and to receive children from him (Klein, 1946; Heimann, 1951).

SUMMARY

The primitive or psychotic anxiety-situations of the first year of life refer basically to the three psychical structures which have been reviewed in this chapter, namely: the paranoid-schizoid position, the depressive position within which the early Oedipus Complex is embedded. The term structure is here used with a specific aim so as to emphasise that they are organizations, or systems, composed of various elements: (a) specific types of anxiety - and therefore a specific set of feelings and experiences which the term anxiety covers; (b) specific modes of object-relations which involve various stages of ego, super-ego and object development. An attempt has been made to map out the development of the phantasy-objects from part to whole objects, including the phantasy-objects that mark the transition from the ones to the others, and (c) specific defence mechanisms which, although different in their functioning, still involve the omnipotent denial of psychical reality. These psychotic structures are defined by the complex set of relations between the various elements that constitute them.

According to Klein these psychical structures are part of normal, neurotic and psychotic development (Klein, 1952). They thus constitute endopsychic structures on a conceptual par with the phallic-Oedipal organization. In other words, the infant in the course of his humanisation has to negotiate the particular conflicts and anxieties which characterise those psychical structures. However, they equally constitute the fixation points for later psychotic disorders in the psychiatric sense of the term: "In earliest infancy anxieties

characteristic of psychosis arise which drive the ego to develop specific defence-mechanisms. In this period the fixation-points for all psychotic disorders are to be found. This hypothesis led some people to believe that I regarded all infants as psychotic, but I have already dealt with this misunderstanding on other occasions" (Klein, 1946 : 292). Although it is conceptually easy to distinguish between the psychodynamic and psychiatric usages of the term 'psychotic' it is at times difficult, in the writings of Klein, to maintain this conceptual distinction and to know with certainty the sense in which the term is being used.

## CHAPTER 5

### OBSESSIONAL SYMPTOMS, MECHANISM

#### AND NEUROSIS : DEFINITION

##### 5.1 Obsessional Symptoms, Mechanism and Neurosis: Definition

In considering Klein's writings on obsessional neurosis (Klein, 1932(a), (b), 1940, 1952(a)) ] it is useful to distinguish between three concepts which have a different logical status. These are: obsessional symptoms, obsessional mechanisms and obsessional neurosis.

- Obsessional symptoms refer to an empirical base, a set of signs and symptoms which are labelled obsessional by virtue of certain characteristics which distinguish them from other symptoms (Section 2.1.1). Thus obsessional symptom is an empirical order concept.
- Obsessional mechanism, trend or defence, terms which Klein uses interchangeably, refer to a set of observables but equally comprise an endopsychic or psychodynamic component which is inferred and not strictly observable. As an example the obsessional mechanism of compulsive accumulation (Section 5.3.2) does not only refer to the behaviour of amassing possessions under various forms, but also involves a specific phantasmatic structure, a specific anxiety situation which is unconscious and in terms of which the manifest behaviour is intelligible.
- Obsessional neurosis is held to be a taxonomic category, a type of psychopathology which is clinically defined and distinct from

other psychopathologies. It comprises both a range of obsessional signs and symptoms and a set of obsessional mechanisms which are structurally integrated so that it becomes clinically distinguishable from other pathological structures.

The relation between the three concepts in Kleinian theory will emerge in the course of this chapter.

## 5.2 The Infantile Neurosis: Animal Phobias and Obsessional Mechanisms

### 5.2.1 The infantile neurosis and obsessional mechanisms

The term infantile neurosis in Kleinian theory refers to all those processes during the early phase of childhood, that is the phase which extends from birth onwards to the onset of latency (Klein, 1952(a) ) which assist in the modification of persecutory and depressive anxiety. "The infantile neurosis, as I see it, therefore begins within the first year of life and comes to an end when, with the onset of the latency period, modification of early anxieties has been achieved" (Klein, 1952 : 81).

In Kleinian theory anxiety is understood primarily in terms of aggression and its viscissitudes (Klein, 1948 ). One of the chief defences against anxiety is constituted by the different forms that the libido takes within the two structural contexts. In the paranoid-schizoid position libido, under the form of idealisation, alleviates persecutory anxiety. In the depressive position, reparation as a particular expression of libidinal urges (Klein, 1935, 1940) alleviates depressive anxiety. If those libidinal mobilisations do not succeed in their

task of modifying psychotic anxiety, fixation points are formed which will favour regressions: "For anxiety leads to fixation to pre-genital stages and again and again to regression to them" (Klein, 1952(a) : 82). A fixation in Kleinian theory is explained in economic terms: if a particular anxiety situation is not properly negotiated a greater mobilisation of libido ensues with the result that less libido is available for progression or for the development of higher order object relations (Heimann and Isaacs, 1952 : 176).

Apart from libido, in its specific structural context, several aspects of development in general contribute to the modification of anxiety. Klein includes the following developmental processes: the acquisition of physical skills; play activities; the development of speech and intellectual progress in general; habits of cleanliness; the growth of sublimations and the important process of symbol-formation; the widening of object relations and the progress in the child's libidinal organisation (Klein, 1952(a) : 81-83). The infantile neurosis thus refers to the totality of processes which lead to a modification of underlying persecutory and depressive anxieties and constitute a way of binding and working them through.

In the course of the infantile neurosis a variety of overt signs and symptoms appear which are an outward manifestation or expression of the underlying psychical conflicts. Early feeding inhibitions, fears of different sorts (strangers, mother's absence), night terrors, hypochondriacal anxieties, excessive thumb-sucking, animal phobias and obsessional trends are a few examples of the manifest symptomatology of the infantile neurosis (Klein, 1952(c), 1932(a) ). Klein has established a specific relation between early animal phobias and the

obsessional mechanisms which both appear during the second year of life, that is, during that period when the anal components of the drive gain in ascendancy and become dominant (Klein, 1932(a) ).

Obsessional mechanisms can be observed "in bed-time rituals, rituals having to do with cleanliness or food and so on, and in a general need for repetition (e.g., the desire to be told again and again the same stories, even with the same expression, or to play the same game over and over again" (Klein, 1952(a) : 84). Such phenomena are part of normal development but Klein treats them as symptoms of the infantile neurosis since they constitute the outward signs of obsessional mechanisms whose role is to keep primitive anxieties at bay: "The lessening or overcoming of these symptoms amounts to a modification of oral, urethral, and anal anxieties; this in turn implies a modification of persecutory and depressive anxieties" (Klein, 1952(a) : 84). If successful in their task, obsessional mechanisms enhance development by allowing the ego to achieve greater integration and strength and thus have an important role in ego-development.

#### 5.2.2 Early phobias and obsessional mechanisms

According to Klein, the psychical processes underlying feeding inhibitions during the first year of life are schizoid in nature: "They consist of fears of violent (i.e., devouring, cutting, castrating) objects, both external and introjected, and such fears cannot be modified in any adequate degree at such an early stage" (Klein, 1932(a) : 219). External objects acquire their persecutory quality because they are projectively identified with the infant's oral, urethral and anal sadistic id urges. When introjected they become internal

persecutory objects or internal persecutors. The first two important internal persecutors are the bad breast and devouring penis. Those two persecutory images form the core of what Klein has called the early super-ego (Klein, 1932(a) ). The early super-ego introjects, in the form of internal persecutors, are imbued with the aggressive cathexes of the id and give rise to persecutory anxiety.

Early feeding inhibitions in Kleinian theory are due to the projection of the early super-ego introjects or internal persecutors onto different types of food: "In the cannibalistic phase children equate every kind of food with their objects, as represented by their organs, so that it takes on the significance of their father's penis and their mother's breast and is loved, hated and feared like these" (Klein, 1932(a) : 220). Thus different types of food, projectively identified with early introjects, become a source of persecutory anxiety, leading to feeding inhibitions.

Early animal phobias are an expression of early anxiety of this kind: "They are based on that ejection of the terrifying super-ego which is characteristic of the early anal-stage, and thus represent a process, made up of several moves, whereby the child modifies its fear of its terrifying super-ego and id" (Klein, 1932(a) : 220). In a first instance the terrifying super-ego is ejected into the external world and identified with the real object. In a second instance, there is a displacement onto an animal of the fear felt of the real father. Thus according to Klein: "Animal phobias are already a far-reaching modification of the fear of the super-ego" (Klein, 1932(a) : 220).

Using this theory of early phobias and animal phobias, Klein gives a different psychodynamic reading of the Wolf-Man's phobia of wolves,

a famous patient of Freud (Freud, 1918). Freud saw the wolf-phobia as a substitute for the castration anxiety inherent in the phallic Oedipus Complex. Klein accounts for this phobia in terms of the more primitive persecutory anxiety deriving from the devouring introjects of the early super-ego, thereby stressing the oral components of such a phobia. The fear of the wolf is primarily a symbolic representation displaced onto an animal of the persecutory fear of the devouring part-object penis, a fear of the primitive internal persecutor (Klein, 1932(a) : 222).

Klein furthermore makes an explicit link between the Wolf-Man's phobia, as indicating strongly operative primitive anxiety situations and his anal-sadistic fixation as evident in his obsessional neurosis, thereby pointing to oral determinants of his particular obsessional neurosis (Klein, 1932(a) : 223-226). As is well known the Wolf-Man in his later years showed paranoid symptoms (Mack Brunswick, 1928).

Klein asserts that in animal phobias, which make their appearance during the anal stage, objects of an intensely terrifying nature are involved. Those objects are similar to the early super-ego introjects operative in infantile feeding inhibitions although animal phobias constitute a significant modification of this early persecutory anxiety. Obsessional mechanisms constitute a further modification of the persecutory anxiety evident in animal phobias: "The process of modification of a phobia is, I believe, linked with those mechanisms upon which the obsessional neuroses are based and which begin to be active during the later anal stage" (Klein, 1932(a) : 226). In other words, the obsessional mechanisms constitute an advance in relation to animal phobias as a means of modifying early persecutory anxiety.

### 5.3 Obsessional Mechanisms

Klein (1932(a) ) has outlined five distinct obsessional mechanisms which are part of both normal and abnormal development. It must be stressed that Klein is not the easiest of writers to decipher and that, in this chapter especially, her lack of concern for systematic writing renders the reader's task extremely arduous. The five obsessional mechanisms fulfill the important function of modifying persecutory and depressive anxieties. Although a variety of writers (Joseph, 1966; Grinberg, 1966; Freedman, 1965) refer to Klein's writings on obsessional mechanisms a systematic exposition of them is nowhere to be found in the literature.

#### 5.3.1 The reaction formations: orderliness, cleanliness, disgust and pity.

The development of the above reaction formation, which becomes exaggerated in the clinical picture of the obsessional neurotic, takes place during the second year of life and is linked to the real situation of toilet training. Although Klein warns against the dangers of precocious and punitive toilet-training (Klein, 1932(a) : 227), she does not espouse the crudely reductionist view that toilet-training per se is responsible for anal-sadistic fixations.

One of Klein's patients, Erna, who was diagnosed as an obsessional neurotic (Klein, 1932(b) ) is a case in point. Erna had been successfully toilet-trained, without difficulty and yet "this outward success went along with a complete internal failure" (Klein, 1932(b) : 82). This internal failure showed in the extensiveness of her anal-sadistic

fixations. If the toilet-training situation is important it is because it evokes in the child specific anxieties and phantasies which derive from the first year of life. In other words it triggers off the primitive anxiety situations, and the potency of the toilet-training situation depends largely on the extent to which the early psychotic anxieties have been modified. If they are still strongly operative then the acquisition of reaction formation will be extremely conflictual and will enhance the chance of strong anal-sadistic fixations.

From the vantage point of psychical reality, that is of the unconscious, the toilet-training situation evokes specific anxieties which are linked to early psychotic situations:

"We get to know the child's fear of its unkind mother who demands back from it the faeces and children it has stolen from her. Thus the real mother (or nurse) who makes demands of cleanliness upon it becomes at once a terrifying person, one who not only insists upon its giving up its faeces, but, as its terrified imagination tells it, who intends to tear them out by force out of its body. Another, yet more overwhelming, source of fear arises from its introjected imagos from whom, in virtue of its own destructive phantasies directed against external objects, it anticipates attacks of an equally savage kind inside itself"

(Klein, 1932(a) : 230).

The persecutory anxiety evoked pertains to the phantasy structure inherent in the paranoid-schizoid position: that of the mother's body (Chart II). As a result of projective identification and introjection, and because of the symbolic value of the faeces, the child feels persecuted by both the external and internal

object. This fear may find expression in a "terror of excreta and dirt in general" (Klein, 1932(a) : 230). The reaction formations of disgust, cleanliness, orderliness, and their extreme manifestations in the form of washing compulsions and avoidance rituals of all sorts, constitute an attempt at modifying this early persecutory anxiety and the fear of the persecutory maternal imago.

In normal development the acquisition of habits of cleanliness leads to an important modification of persecutory anxiety. Firstly, control of the sphincter proves to the child that he can control his inner dangers and his internal objects (Klein, 1932(a) ). Secondly, by parting with his excrements in conformity with the maternal/cultural demand, the child submits his internal dangers to the process of reality-testing. By satisfying the maternal demand, by being 'clean' the "actual excrements serve as evidence against its phantastic fears of their destructive quality" (Klein, 1932(a) : 227). The nature of the faeces changes and becomes 'good'. This in turn leads to a modification of the internal and external object which becomes less persecutory.

On the other hand, the reaction formations help to modify depressive anxiety. Even in her early writings, Klein makes use of the concept of reparation and omnipotent reparation (Klein, 1932(a) ) although these two concepts are not given their place within the psychical structure which she later articulated as the depressive position (Klein, 1935, 1940). The reactive feeling of pity is a means whereby the child guarantees the safety of the object in the context of more advanced object relations. The acquiring of habits of cleanliness, by giving the 'good' faeces to mother who demands it, also diminishes

guilt and satisfies the drive to make reparation (Klein, 1932(a) : 227). Similarly, obsessional cleanliness and orderliness is a way of symbolically cleaning up or restoring whatever the child has dirtied or spoiled. "It has to beautify and restore the damaged thing in all number of ways in accordance with the variety of its sadistic, phantasies and the details contained in them" (Klein, 1932(a) : 232).

### 5.3.2 The mechanism of compulsive accumulation (retention) and giving.

Parsimony and miserliness are typical anankastic or anal personality traits. Retaining and giving are zones of conflict in the obsessional neurotic. Klein, on the basis of her psychoanalytic work with young children, gives her own interpretation of this particular obsessional mechanism: "The compulsive accumulation of things and giving away of them becomes more intelligible as soon as we are able to recognise more clearly the nature of the anxiety and sense of guilt which underlies an exchange of goods on the anal level" (Klein, 1932(a) : 233).

With young children, in the play therapy situation, compulsive taking and giving takes diverse expressions such as: transferring the contents of a box to another, carefully arranging them and counting one by one. A multiplicity of objects enter this commerce: burnt matches, paper patterns, bricks, bits of string and so on. For Klein, the fantasy-structure which underlies such play material is that of the mother's body and the objects exchanged are symbolic representatives of the contents of mother's body: father's penis, children, pieces of stool, urine, milk (Klein, 1932(a), (b) ).

Freud pointed out in his case-history of the Wolf-Man how, when the anal complex was analysed the Wolf-Man's constipation gradually subsided and the bowel began "to join in the conversation" (Freud, 1919 : 239). Klein similarly points out how in the course of analysis "very often children will be interrupted in their representation of 'giving back' by having to go to the lavatory to defaecate" (Klein, 1932(a) : 236), stressing thereby the direct link between bodily retention/evacuation and its symbolic representatives at the level of the psychical metaphor.

Anal exchange is fraught with two types of anxieties. On the one hand accumulation of symbolic objects is a means of warding off the persecutory fear of the maternal image who is going to demand back what has been stolen from inside her body. On the other hand accumulation means having enough so as to restore the damage done in phantasy: it alleviates guilt and depressive anxiety.

Three particular dilemmas pervade anal exchange and increase the anxiety of the child. Klein stresses the concrete nature of giving back what has been stolen or destroyed in phantasy: "It is concerned with manifold injuries and acts of destruction done inside the body, and therefore it is inside the body that restitution has to be made" (Klein, 1932(a) : 231 - our emphasis). The three dilemmas of the child are as follows:

- Firstly, the child doubts his ability to give back because of his own small body in comparison to the big body of the adult: "... they feel they cannot give back out of their own small body all they have taken out of their mother's body which is so large in comparison" (Klein, 1932(a) : 234). One of Klein's patients,

John, who showed strong obsessional controls in play therapy, expressed such an uncertainty in the following terms: "One can't take thirteen from ten or seven from two" (Klein, 1932(a) : 232). Thus anal exchange is fraught with doubt or uncertainty about one's ability to give back which increases the anxiety and the need to accumulate.

- Secondly, the child does not know whether his reparative actions have put right the damage done inside the mother's body: "But the child cannot know anything for certain about the inside of the body, whether its own or that of its objects" (Klein, 1932(a) : 232). This uncertainty, lack of knowledge and lack of trust in the child's own reparative powers constitute the deepest motivations for the obsessional desire for knowledge. Obsessional knowing, the accumulation of ideas, with its extra emphasis on reality, detail and over-precision is a desperate attempt by the child to ward off a world fraught with persecutory and depressive anxieties.

- Thirdly, reparative giving back is marred by the child's doubt as to the good-enough nature of what is to be given back. By good-enough is not meant only equal in value to what has been greedily stolen or destroyed but also whether it is innocuous and free from poison since urine and faeces signify dangerous substances (Klein, 1932(a) : 235). In other words, the reparative act is fraught with paranoid anxieties deriving from the destructive nature of the part-object faeces.

It is evident that for Klein what underlies compulsive accumulation

and giving back are the sadistic urges and phantasies which permeate the object-relationship to the mother's body and its contents.

As an illustration she quotes from the analysis of John, a five-year old patient, with severe constipation and a need to store up his faeces so as not to feel empty (Klein, 1932(a) ). John was deeply anxious about the possibility of his stool melting away and his inability to make enough of it. His obsessional behaviour was an attempt to ward off this more primitive, disintegrative anxiety. However, due to the dilemmas (doubts, uncertainties) that permeate obsessional retention and exchange, and the increase in anxiety, they lead to, his primary destructive tendencies would often emerge in therapy. Thus "he would tear, cut to pieces, and burn the things he had made when his reactive tendencies were uppermost ... and his thirst for destruction would be insatiable" (Klein, 1932(a) : 236). The primitive sadistic attacks onto mother's body with the help of urine and faeces were manifested in his destructive outbursts and "underlay that impulse to make restitution which found expression in his obsessional mechanism" (Klein, 1932 (a) ; 236).

### 5.3.3 The obsessional coercion of others

Obsessionals usually exercise an often intolerable coercion on people in their surroundings. According to Klein this controlling stance is a result of a manifold projection: "In the first place he is trying to throw off the intolerable compulsion under which he is suffering by treating his object as though it were his id or his super-ego and displacing upon it the coercion they exercise upon him. In doing this he is incidentally satisfying his primary sadism by

tormenting or subjugating his object" (Klein, 1932(a) : 232).

Although Klein in 1932 had not yet used the term projective identification this is perhaps one of the clearest descriptions of this particular mechanism before her definitive paper "Schizoid mechanisms" on the subject (Klein, 1946). In so doing, Klein assimilates this particular mechanism of control to the group of defences known as the schizoid defences, which operate in the paranoid-schizoid structure, and form an intrinsic part of the psychodynamic picture of psychotics and of the borderline personality.

Part of the self is projectively identified with another in an attempt to ward off the persecutory anxiety generated by the internal persecutor: "In the second place he is turning outward on to his external object what is ultimately a fear of being destroyed or attacked by his introjected objects. This fear has aroused in him a compulsion to control and rule his imagos, and since he can never in fact do this he tries to tyrannise over his external objects" (Klein, 1932(a) : 232)

Schizoid object-relations are essentially narcissistic since the other becomes the representative of 'good' and 'bad' parts of the self through the mechanism of projective identification. The projection of good parts of the self leads to idealisation and the projection of bad parts leads to persecution. Both these types of narcissistic relations involve control of the other person and "the impulse to control others is, as we know, an essential element in obsessional neurosis" (Klein, 1946 : 306).

Thus according to Klein this particular obsessional mechanism of

coercion is a schizoid one and involves radical splitting and omnipotent denial of psychological reality. This involves a state of indistinction between self and other, a narcissistic object-relation: "One root of obsessional mechanisms may then be found in the particular identification which results from projective processes" (Klein, 1946 : 306).

#### 5.3.4 Omnipotent destruction and omnipotent reparation

If the obsessional coercion of others is a schizoid defence mechanism Klein, in her early writing, describes the attempt at omnipotent reparation underlying obsessions in a way which bears great resemblance to what she later called the manic defences (Klein, 1934, 1940).

Freud had depicted the omnipotent quality of obsessional thoughts (Freud, 1909). Undoing as a defence mechanism is based on this belief that thoughts and wishes are equivalent to deeds and can be magically 'blown away' with the help of other thoughts (Freud, 1926). Thoughts are thus omnipotently over-valued.

Klein uses this Freudian hypothesis and develops it in her own way. She inserts the phantasy-structure of the combined parental figure (Section 4.5.2) in the phase of narcissism during which the infant's omnipotence extends to both his thoughts, wishes and his anal products (Klein, 1932(a) ; Heimann, 1952 : 144-145). The oral, urethral and anal phantasy attacks on the essentially depriving parental couple are felt by the child to have caused omnipotent destruction. As a consequence reparation has to be carried out on an omnipotent

scale: "When their sense of guilt sets in motion obsessive actions as a defence, they will employ that feeling for the purpose of making restitution. But they now have to sustain it in a compulsive and exaggerated way, for it is essential that the acts of restitution they make should be based on omnipotence, just as their original acts of destruction were" (Klein, 1932(a) : 239) (Our emphasis).

Omnipotent reparation is an intrinsic element of the manic defences (refer to 4.4.3). What then distinguishes the particular obsessional mechanism, which underlies various obsessional symptoms, from the manic defences? Klein herself in her early work has difficulty in explaining this distinction. "This mechanism does not seem to be typical for obsessional neurosis. The patients in whom I have observed it presented a clinical picture of a mixed type, not a purely obsessional one" (Klein, 1932(a) : 261). In this early paper it is only the phenomenon of displacement onto trifles which allows a distinction between obsessional and manic reparation: "In virtue of the mechanism of displacement onto trifles, which plays so great a part in his neurosis, the obsessional can seek in very slight achievements a proof of his constructive omnipotence ..." (Klein, 1932(a) : 261). Thus the distinguishing element appears to be a formal one: it lies in the form of the symptom with its emphasis on detail.

After the formulation of the depressive position Klein made more explicit the relationship between the manic and the obsessional defences (Klein, 1934, 1940). In 1934 she asserts that the reparative tendencies which play such an important role in overcoming the depressive anxiety are set in motion by two different methods: the manic and the obsessional defences. In 1940, Klein elaborates on the relation-

ship between those two modes of defence which operate simultaneously. She posits the obsessional defence as an alternative to the manic defences: "The young child who cannot sufficiently trust his reparative, constructive feelings, as we have seen, resorts to manic omnipotence. For this reason, in an early stage of development the ego has not adequate means at its disposal to deal efficiently with guilt and anxiety. All this leads to the need in the child - and for that matter to some extent in the adult also - to repeat certain actions obsessively (this in my view is part of the repetition compulsion); or - the contrasting method - omnipotence and denial are resorted to" (Klein, 1940 : 350). Thus the obsessional defence is an alternative to the manic defence. The difference between the two however is not clear apart from the brief reference to the compulsion to repeat in the case of the obsessional defence and omnipotent denial in the case of the manic defence.

Furthermore, these two types of defences are interchangeable: "When the defences of a manic nature fail (defences in which dangers from various sources are omnipotently denied) the ego is driven alternately or simultaneously to combat the fears of deterioration and disintegration by attempted reparations carried out in obsessional ways" (Klein, 1940 : 351).

Although the paranoid-schizoid and depressive positions are chronologically distinct, in reality they overlap and at the time of the depressive position paranoid fears and schizoid defences are equally operative (Klein, 1940). "The desire to control the object, the sadistic gratification of overcoming and humiliating it, of getting the better of it ... may enter so strongly into the act of

reparation ... that the benign circle started by this act becomes broken. The objects which were to be restored change again into persecutors, and in turn paranoid fears are revived. These fears reinforce the paranoid defence mechanisms (of destroying the object) as well as the manic mechanisms ... The reparation which was in progress is thus disturbed or nullified - according to the extent to which these mechanisms are activated. As a result of the failure of the act of reparation, the ego has to resort again and again to obsessional and manic defences" (Klein, 1940 : 351). But here again, although a rapprochement between the manic and obsessional defence is established, both defend against persecutory and depressive anxiety. Both in the very act of omnipotent reparation betray their underlying sadism and lead to the 'benign circle'. It is not clear what distinguishes them.

In the same article (Klein, 1940) Klein returns to the earlier theme of the form a particular defence takes. Describing the hypomanic state Klein lists the following features: over-valuation (idealisation) and contempt (devaluation); the tendency to conceive of everything on a large scale, to think in large numbers in accordance with the greatness of omnipotence which is a means of denying the dependency, guilt, love for the object; casualness about detail, contempt of conscientiousness. All those features "contrast very sharply with the meticulous methods, the concentration on the smallest things (Freud), which are part of the obsessional mechanisms" (Klein, 1940 : 352). It appears that Klein here resorts to the manifest features of obsessional symptomatology, that is displacement onto trifles, in contrast to the exaltation of self which characterises a manic state, so as to distinguish between the manic and obsessional

defence. But dynamically speaking they both fulfill the same function and are interchangeable: they are both omnipotent ways of carrying out reparation in an attempt to ward off depressive anxiety, and paranoid anxiety. In other words, apart from a formal difference, they are assimilable. Klein fails to point out what are the specific factors which favour a particular mode of defence.

#### 5.3.5 The obsessional desire for knowledge

Thinking, knowing and the reliance on abstraction play an important role in obsessional neurosis. As had been pointed out by Freud, obsessional thinking, in an attempt to ward off instinctual urges, often betrays the id impulse. More specifically, Freud referred to the obsessional desire for knowledge as taking the place of sadism in the mechanism of obsessional neurosis (Section 3.6.1).

Klein proposes to explain Freud's empirical observation. The phantasy-object of the mother's body and its contents is the focus of intense libidinal and destructive urges on the part of the infant. Accompanying the child's sadistic urges to take possession of the mother's body and its contents, via the mechanism of projective identification, is the intense desire to know what is going on and what things look like in there: "In this way its wish to know what there is in the interior of her body is assimilated in many ways with its wish to force a way inside her, and the one desire reinforces and stands for the other" (Klein, 1932(a) : 242). Thus for Klein the beginnings of the epistemophilic urges are closely associated with sadistic urges to take possession and exert omnipotent control.

However, this early situation is fraught with persecutory anxiety. The desire to know is simultaneously a means of warding off anxiety.

If the anxiety is too great it in turn leads to an inhibition in knowledge: "Knowledge becomes a means of mastering anxiety, and its desire to know becomes an important factor both in the development of its epistemophilic instincts and their inhibitions"(Klein, 1932 (a) : 342).

Klein gives the clinical example of Erna's severe learning inhibition (Klein, 1932(b) ). Erna was prone to obsessive brooding at a very young age and was uneducable at school (Klein, 1932(b) : 66). Material from Erna's play analysis reveals feelings of intense hatred towards her mother derived from her early Oedipus situation, her savage phantasy attacks onto the combined parental figure in which excrements featured prominently as a vehicle of attack. This destructive hatred was accompanied by the paranoid phantasy of a 'robber woman who would take out everything inside her' (Klein, 1932(b) : 70), that is, of a persecutory anal mother as a result of projective identification. Within the context of such a primitive anxiety situation, Klein analyses Erna's inhibition in learning as follows: " ... the child's terror of knowing everything about the fearful destruction it had done to its mother's body in imagination and the consequent counterattacks and perils it was exposed to was so tremendous that it set up a radical disturbance of its desire for knowledge as a whole, so that its original, intensely strong and unsatisfied desire to get information about the shape, size and number of its father's penises, excrements and children inside its mother had gone over into a need to measure, add up and count things in a compulsive way" (Klein, 1932(a) : 243). The obsessional and meticulous concern

for detail, which perverted her learning ability, was in fact a desperate attempt at mastering the persecutory anxiety resulting from her own destruction. The obsessional desire for knowledge was a way of gaining omnipotent control over the persecutory internal and external imago.

#### 5.4 Obsessional mechanisms, obsessional neurosis and age of onset.

"The process of modification of a phobia is, I believe, linked with those mechanisms upon which the obsessional neuroses are based and which begin to be active in the later anal stage" (Klein, 1932 (a) : 226). According to Klein obsessional mechanisms constitute the core foundation upon which an obsessional neurosis is built. It has been shown that some of the obsessional defences are omnipotent in nature, that they come into action at a time when psychological reality is still fraught with persecutory or damaged images, and that their main aim is to modify persecutory and depressive anxiety.

If the obsessional defence is strong and achieves developmental dominance it means that the early anxiety-situations have not been successfully modified and that an early conflict in the anal-phase results. In other words the anal-sadistic fixation is a direct result of the failure in resolving early anxiety-situations. It is the anal-sadistic fixation which constitutes the foundation upon which an obsessional neurosis is based: "The accepted theory is that fixations at the anal-sadistic stage do not come into force as factors in obsessional neurosis until later on, as a result of a regression to them. My view is that the true point of departure for obsessional neurosis - the point at which the child develops obsessional symptoms and

obsessional mechanisms is governed by the later anal stage" (Klein, 1932(a) : 227 - our emphasis).

Klein accepts that there is a difference between the organised obsessional neurosis of adulthood and the early obsessional trends which appear during the second year of life. She attributes this difference to the fact that "it is not until later, in the latency period, that the more mature ego, with its altered relationship to reality sets out to synthesise and elaborate those obsessional features which have been active since early childhood" (Klein, 1932(a) : 227). Klein puts forward the argument that the ego is still too weak during the anal phase to successfully modify the anxiety by obsessional means and it has to resort to other mechanisms of defence still operative in order to modify both persecutory and depressive anxiety. As a consequence the obsessional traits of the small child are often not easily discernible because of their admixture with earlier disorders and earlier defence mechanisms (Klein, 1932(a) : 227). During latency, both the ego and the super-ego have gained in strength, they present a common front to the id, and the obsessional neurosis can be systematised into a coherent whole (Klein, 1932(c) : 258).

However, although this may be the case, the later development of the ego and super-ego do not constitute a necessary ingredient in the formation of an obsessional neurosis. "Nevertheless as I have tried to show, even quite young children frequently exhibit symptoms of a distinctly obsessional type, and there exists infantile neuroses in which a true obsessional neurosis already dominates the picture. When this is the case it means that the early anxiety-situations are too powerful and have not been sufficiently modified and that the obsessional

neurosis is a very grave one" (Klein, 1932(a) : 228). Klein is making two assertions in this passage. Firstly, she unambiguously asserts that an obsessional neurosis can be diagnosed in a very young child who exhibits strong obsessional controlling mechanisms during the anal phase. Her two young patients, Rita and Erna were both diagnosed as obsessional neurotics from the young age of two (Klein, 1932(a), (b) ). Secondly, she asserts that if the obsessional symptoms dominate the infantile neurosis at such an early age then the obsessional neurosis is a very grave one. Although she does not elaborate on the term grave a plausible interpretation is that the type of obsessional neurosis developed is severe because of the early psychotic disturbances that still prevail.

#### 5.5 Obsessional Neurosis and Psychosis

If the kernel of obsessional neurosis, that is the obsessional mechanisms, operate in conjunction with, or, are partly assimilable to, other more primary defence mechanisms which are active during the first year of life, in their attempts to modify persecutory and depressive anxieties, where does Klein place obsessional neurosis along the psychosis-neurosis continuum?

Klein makes an explicit link between obsessional neuroses in their severe form and paranoia (Klein, 1932(a) ). In her early work Klein still adhered to Abraham's theory of psycho-sexual development (Abraham, 1926). Abraham posited a distinction between the early and later anal-sadistic stage. For Abraham a regression to the early anal stage would constitute an essential ingredient in the formation of paranoid symptomatology. Whereas regression to the

second anal-sadistic stage is an essential ingredient in the formation of an obsessional neurosis (Abraham, 1926). Thus the distinction between the early and later anal-stage constitutes a demarcation line between psychosis and neurosis.

From within Abraham's framework Klein makes the following statement: "In the early anal-sadistic stage the individual, if his early anxiety-situations are strongly operative, actually passes through rudimentary paranoid states which are normally overcome in the next stage, and the severity of his obsessional illness depends on the severity of the paranoid disturbances that have immediately preceded it" (Klein, 1932(a) : 232-33). The adjective psychotic in Klein has an ambiguous meaning in that it both refers to a psychological structure characterised by a type of anxiety and a set of defences to combat the anxiety, and also to a psychiatric diagnosis made on the basis of empirical signs and symptoms. In linking obsessional neuroses to paranoia, however, Klein makes a connection between two diagnoses. This connection is concretised in her discussion of Erna, the young obsessional neurotic: "As the analysis went on I discovered that the obsessional neurosis masked a paranoia" (Klein, 1932(b) : 160). This particular hypothesis seems to be accepted amongst Kleinians. Thus Betty Joseph, an eminent Kleinian analyst, showed at the 1965 Congress how, as the acute paranoid anxieties of a five-year old boy were analysed an obsessional organization with rigid controlling and dominating ruminations and rituals took over (Joseph, 1966 : 184). It must be said, however, that Joseph leaves open the question as to whether this child is likely to show just a rigid obsessional character or classical obsessional neurosis.

Although Klein has shown how closely the obsessional and manic defences operate in early childhood, nowhere has she made the explicit link between manic-depressive psychosis and obsessional neurosis. But owing to the combined operation of both defensive organizations, it is not implausible to assume that, from a Kleinian viewpoint, severe obsessional neuroses may equally mask a manic-depressive psychosis.

#### 5.6 The Early Super-ego and Obsessional Neurosis

"My contention that obsessional neurosis is a means of modifying early anxiety-situations and that the severe super-ego which figures in it is no other than the unmodified, terrifying super-ego belonging to early stages of the child's development, brings us, I think nearer to a solution of the problem of why the super-ego should in fact be such a severe one in this neurosis" (Klein, 1932(a) ; 229).

For Klein the more mature super-ego which is consolidated during the latency phase is preceded by earlier forms active in the very first part-object relations to the breast (Klein, 1952(b) ). The world of the young infant is fraught with benevolent and persecutory images. The external object owing to the mechanism of projective identification receives the full cathexis of the id impulses, of both the libidinal and destructive drives. Owing to introjective mechanisms the idealised and persecutory objects are internalised within the ego: "The good internalised breast and the bad devouring breast form the core of the super-ego in its good and bad aspects" (Klein, 1952(b) : 280).

The second object to be introjected is the father's penis in

both its good and bad aspects. "These two dangerous objects - the bad breast and the bad penis - are the prototypes of internal and external persecutors" (Klein, 1952(b) : 280). The logic of the paranoid-schizoid position is such that the internal persecutors, increase persecutory anxiety which again reinforces the infant's aggressive impulses and phantasies which are projected into the already terrifying imagos. This escalation in persecutory anxiety is prevented to a large extent by the schizoid defences (Section 4.3.2). The early super-ego prototypes however are extremely harsh and severe and felt by the ego as persecutory and annihilatory. The early phobias of the child are representations of the internal persecutors.

It is during the depressive position that the nature of introjective processes changes dramatically. The splitting processes diminish in intensity and love and hate are felt towards the same whole object. Thus ambivalence, guilt and depressive anxiety, as a new set of experiences, give an increasingly poignant quality to the psychological reality of the child. The introjected image is now a whole person felt to be injured, suffering or in a state of deterioration. It is the emotion of guilt which sets the reparative urges in motion: "The reparative tendency can, therefore, be considered as a consequence of the sense of guilt" (Klein, 1948 : 285).

Klein, however, stresses that, although the two positions are conceptually distinct, in reality they operate jointly. During the depressive position persecutory images are still operative and the schizoid mechanisms are deployed to modify it: "But even during the next stage, the depressive position, in which the more integrated ego introjects and establishes increasingly the whole person,

persecutory anxiety persists. During this period ... the infant experiences not only grief, depression and guilt, but also persecutory anxiety relating to the bad aspects of the super-ego; and defences against persecutory anxiety exist side by side with defences against depressive anxiety" (Klein, 1952(b) : 285).

The early super-ego is thus made up of an admixture of persecutory part-objects felt as persecutory anxiety, and of reproaching damaged whole objects felt as a sense of guilt. The function of obsessional mechanisms is to appease, pacify or annihilate the persecutors on the one hand and to make reparation to the damaged internal whole objects on the other. It is within this context that the extremely harsh and archaic quality of the obsessional neurotic's super-ego is to be understood. It is a direct expression of the early super-ego which is made up of primitive part-objects and damaged whole objects.

### Summary

In this chapter five obsessional mechanisms as depicted by Melanie Klein have been outlined. According to Klein, they constitute the foundation of obsessional neurosis. An inconsistency as regards the time at which obsessional mechanisms emerge in the course of development may have struck the reader. Initially (Klein, 1932(a) ) Klein adhered to Abraham's distinction between the early and later anal-sadistic stage. Thus, in her early writings she locates the emergence of obsessional mechanisms in the second anal-stage (Klein, 1932(a) ). After the formulation of the two positions, however, Klein locates the emergence of obsessional mechanisms in the second year of life without reference to Abraham's distinction (Klein, 1952(a) ).

This apparent inconsistency can be understood as a result of the formal articulation of the paranoid-schizoid position which operates in the first few months of life. If this position, and its various elements, underlies later psychotic disorders then the demarcation introduced by Abraham is made redundant in the more mature Kleinian theory.

It has been pointed out that obsessional mechanisms operate in close conjunction with the manic and schizoid defensive organizations, and that they fulfill the main function of modifying persecutory and depressive anxiety. The author has attempted to show, as clearly as Klein's writings permit, the specific object-relations within which obsessional mechanisms are deployed.

Finally, the link between obsessional neurosis and psychotic disorders has been outlined although Klein's views on the subject are not fully developed

## CHAPTER 6

### Critical Comparison between the Classical Etiological Formula and the Kleinian Viewpoint on Obsessional Neurosis

#### AIMS

In this chapter a comparison between the classical and Kleinian viewpoints will be established. This comparison entails differences of a more general consideration which exist between Freudian and Kleinian theory per se. Reference to those broader differences will be made when relevant. However, in the main, the comparison will be restricted as much as possible to the precise subject of obsessional neurosis.

#### 6.1 The regression hypothesis and the Oedipus Complex

The pivotal element of the classical etiological formula is the regression from the phallic-Oedipal to the anal-sadistic libidinal organization (Section 3.4.2). It has been shown that such a theoretical hypothesis is established on the basis of clinical facts - the admixture of genital, phallic-Oedipal and anal-sadistic elements in the clinical picture - and also in terms of the fact that obsessional neurosis exaggerates some of the ways normally employed in the resolution of the Oedipus Complex (Section 3.4.2 and 3.5). The upshot of such an explanatory hypothesis is that the formation of an obsessional neurosis assumes the relatively unimpaired attainment of the phallic-Oedipal structure. Obsessional neurosis, hysteria,

'normality' are all particular solutions of the conflicts inherent in the phallic-Oedipal psychical situation. On the other hand, drive regression is the likeliest avenue because of the fixations that have occurred during the anal-sadistic phase of development. Although important, etiologically speaking, the anal-sadistic fixation per se cannot provide an explanation for an obsessional neurosis. Thus an anal-sadistic fixation can be seen to underlie a variety of psychopathological configurations of which obsessional neurosis is one. For example: encopresis in children, a type of male homosexuality (Sandler and Joffe, 1965), certain perversions (Grunberger, 1966) equally assume an anal-sadistic fixation. Thus in order to explain the formation of an obsessional neurosis other ingredients are essential, namely: the type of ego formation, the type of defences employed by the ego, the defusion of the drive, the super-ego regression and the regression from the phallic-Oedipal organization. The phallic-Oedipus complex is the kernel of obsessional neurosis in Freudian theory.

What importance does Klein assign to this cornerstone of the classical formula? For Klein, the core and the real starting point of an obsessional neurosis are the obsessional mechanisms which come into operation during the anal phase, in the second year of life (Sections 5.2.1, 5.2.2). If Klein does concede that the obsessional manifestations appearing at that time are loosely organised and that later ego and super-ego developments are important in giving obsessional neurosis its adolescent or adultform, she does not invoke the phallic-Oedipal structure, and the regression thereof, as an essential etiological ingredient (Section 5.3). In fact Klein unhesitatingly makes the diagnosis of obsessional neurosis in two-year old children which

means that an obsessional neurosis can be fully formed at the time at which the anal-sadistic fixation is taking place.

This difference is tantamount to saying that Klein by-passes and devalues the most important etiological tenet of the classical formula, which as has been shown is rich from an explanatory point of view. It appears that for Klein the anal-sadistic fixation carries the most etiological weight in the explanation of obsessional neurosis (refer to Section 6.2). Is Klein, who in many respects acknowledges a constant debt to her Freudian heritage, aware of this contradiction and if she is how does she propose to resolve it?

In her 1932(a) article Klein addresses herself directly to the contradictions. She writes: "At first glance it would seem that this idea that certain elements of obsessional neurosis play an important role in the clinical picture presented by infantile neuroses is at variance with what Freud has said concerning the starting-point of obsessional neurosis" (Klein, 1932(a) : 226). Having outlined the difference she goes on to maintain it by asserting that the true point of departure of obsessional neurosis is the time at which the child develops obsessional mechanisms. In the next step of her argument Klein refers directly to the passage in which Freud reiterates that "... this regression is decisive for everything that follows" (Klein, 1932(a) : 228). She then attempts to assimilate the Freudian hypothesis within her own formulations on regression and the early Oedipus Complex. This passage deserves to be quoted in full:

If we regard as a regression that fluctuation between the various libidinal positions which is, in my opinion, a

characteristic of the early stages of development and in which the already cathected genital position is continually being abandoned for a time until it has been properly strengthened and established, and if my contention that the Oedipus Complex begins very early is correct, then the view here maintained about the point of departure of the obsessional neurosis would not only not be in contradiction with Freud's view as quoted above, but would go to bear out another suggestion of his ..."

(Klein, 1932(a) : 228, our emphasis)

Klein's attempt at assimilation requires close logical scrutiny and the argument put forward here is that it fails. In Kleinian theory the Oedipus Complex starts early: it is a part-object Oedipus Complex to start with and only gradually develops into the genital Oedipus Complex as articulated by Freud (Section 4.5.2). However, the differences between the early Oedipus Complex and the later genital one cannot be minimised. The former is fraught with persecutory and depressive anxieties. The relationships are with part-objects (breast/penis) and damaged whole objects. The ego which is still extremely unintegrated and fragile makes use of the schizoid and manic defences in which projective and introjective mechanisms feature prominently and the super-ego introjects are harsh and severe and inherit directly the cathexes of the id. In comparison, the genital Oedipus Complex is fraught with castration anxiety (qualitatively different to annihilatory and depressive anxieties). Its relationships are dominantly with whole objects; the ego being more integrated makes use of different defence mechanisms such as repression, reaction formation, isolation and is less prone to vertical splitting. The

The super-ego introjects are less severe owing to neutralisation (Section 3.5). Furthermore, the genital symbolic register of the drive colours the more mature object-relationships. In other words, the early and genital Oedipus Complexes are different psychical structures and the similarities that do exist between them are not sufficient for an assimilation of the two. In the passage cited above, Klein pays no heed to those important structural differences.

As regards the Kleinian theory of regression and fixation it is true that it differs from its Freudian counterpart (Heimann and Isaacs, 1952). The main difference is that for Kleinians the libidinal stages are not as sharply delineated: oral, urethral, anal and genital trends are active at the time of the early Oedipus Complex (Section 2.5). But they are trends and Klein still subscribes to the concept of phase dominance. Even after her postulation of the depressive and paranoid-schizoid positions, Klein still adheres to the accepted notion that the drive progresses through a hierarchy of phases during which particular drive registers, which colour the object-relationships, dominate. Thus the early super-ego introjects are devouring indicating their oral anchorage. Similarly, the relationship to the persecutory mother inherent in the psychical structure of anal exchange (Section 5.2.2) is marked by an anal maternal imago. The conflicts within that particular psychical situation are between: retaining and giving, having enough or not having enough inside the body and the good-enough or poisonous gift. They are anally anchored and expressed in the language of anality.

For Klein it is feasible to conceptualise temporary regressions and progressions from one trend to another within a particular phase-

dominant organization (Heimann and Isaacs, 1952). Thus prior to the attainment of the anal phase, it is conceivable that the anal-sadistic trends gain in strength at the expense of the genital trends. However, and this is the central point that needs emphasis, it is not admissible to equate this particular dialectic between component drive trends with a regression from the phallic-Oedipal to the anal-sadistic organization as Freud meant. By the same token, Klein could posit a regression to the anal-sadistic before the child has properly entered the anal phase, a proposition which is obviously absurd. It is clear that in her attempt to assimilate her ideas to those of the classical formula, Klein does not respect her own distinction between drive trends and phase organization. As a result her attempt at rapprochement fails. The contradiction remains: the regression hypothesis, central to the classical formula of obsessional neurosis is not a necessary etiological ingredient from the Kleinian viewpoint.

## 6.2 The age of onset and the anal-sadistic fixation

The question of the age of onset is directly linked to the regression hypothesis. It is thus logically consistent, given the existing difference between Freud and Klein as regards the regression hypothesis, that both authors should be in disagreement on the age of onset. For Freud the age of onset can only be post-Oedipal (Section 3.8). For Klein obsessional neurosis can be diagnosed in the pre-Oedipal child (Section 5.3) and more specifically at the time at which the child develops his obsessional mechanisms. It has been pointed out that if obsessional mechanisms are strongly operative, they indicate that earlier psychotic anxieties are being warded off and that anal-sadistic fixations are being established (Section 5.2.2).

It appears therefore that in Kleinian theory the most important etiological factor is the anal-sadistic fixation of the drive.

Klein herself attempts to bring her theory on the true point of departure of obsessional neurosis close to Freud's tentative hypothesis as regards precocious ego-development during the anal-sadistic phase (Klein, 1932(a) : 229). Freud did consider that the outstripping of drive development by ego development during the anal-sadistic phase might be the key etiological factor in explaining the anal-sadistic fixation and obsessional neurosis (Freud, 1926). However, Freud left this hypothesis in abeyance and reasserted the decisive etiological role of the regression from the Oedipal organisation (Section 3.4.2). Furthermore, the ego-psychologists who subscribe to, and have developed the notion of precocious ego development further, still adhere to the all-important regression as the main causative factor. It thus seems that Klein cannot draw the support she would like (Klein, 1932(a) : 228) from Freud's writings (Freud, 1926) for her hypothesis on the true point of departure of obsessional neurosis. Because Klein disregards the etiological role of the phallic-Oedipus complex, her position is tantamount to giving causal priority to the anal-sadistic fixation and this allows her to diagnose obsessional neuroses in pre-Oedipal children.

The age of onset and the question of childhood obsessional neuroses thus become an important empirical source of data which can be used to corroborate controversial theoretical statements. Those empirical studies, however, are subject to two limitations. Firstly, they are few and far between and this is due to the fact the incidence of childhood neurosis is very low. For example, in major epidemiologic surveys such as the Isle of Wight (1970), conducted amongst 2 000

10- and 11-year olds, no cases of obsessional neurosis were found. The study therefore must be conducted through case finding (Rappoport et al, 1981). Secondly, natural history studies are usually conducted by psychiatrically trained people who use diagnostic criteria which are less supple and less psychodynamically based than those which would be used by psychoanalytic researchers. However, far from being ideal, the value of the existing surveys as an independent source of information, cannot be contested. Three studies (Section 2.3.1), those of Bermann (1942), Judd (1965) and Rappoport et al (1981) all report a mean age of onset which is clearly post-Oedipal and found no obsessional neurotics under age 5. Their studies would thus tend to corroborate the Freudian statement on the post-Oedipal age of onset. Only Adam's study (1973) reports cases of obsessional neurosis in children under age 5. As has been pointed out (Section 2.3.1) Adams study lacks rigour. It does not make a sufficient distinction between state and trait. Adams relied on parental reports rather than direct observation, a methodology open to strong experimenter bias. It can be tentatively put forward that the existing literature on the topic of childhood obsessional neuroses and age of onset tends to favour the classical viewpoint rather than the Kleinian. Caution must be exercised though and the existing evidence can at best be treated as indirect confirmation because of the limitations of such studies.

Nevertheless it is obvious that the question of childhood obsessional neurosis is a controversial issue not only on purely empirical grounds but also because it is relevant to the particular theoretical differences that exist between the classical and Kleinian viewpoint on the etiology of obsessional neurosis. At this juncture it is appropriate to review the symptomatology of Klein's two very young patients, Rita and Erna (Klein, 1932), and to compare theirs

to the symptomatology of the Rat-Man who manifested a prototype of his later neurosis in his latency phase (Freud, 1909).

### 6.3. Rita, Erna and the Rat-Man

Rita and Erna were both young children who Klein diagnosed as suffering from an obsessional neurosis (Klein, 1932). They constitute at least part of the sample on which Klein developed her theory of obsessional mechanisms and obsessional neurosis. In her theoretical chapter on the syndrome (Klein, 1932(a)) Klein makes constant references to both cases.

Rita was referred to Klein at age 2<sup>3</sup>/<sub>4</sub> years old with the following presenting problems (Klein, 1932 : 23-30):

- A time consuming bed-time ceremonial, since age 2, "performed with every sign of that compulsive attitude which pervaded her whole mind" (Klein, 1932 : 27). Rita had to be tightly tucked up in her bed-clothes and her doll had to be tightly tucked up too.
- Severe anxiety manifested in night terrors and a general fear of animals.
- Abnormal mood states "which showed all the signs of melancholic depression" (Klein, 1932 : 24).
- Episodes of exaggerated goodness, love of order and cleanliness, usually accompanied by feelings of strong remorse, which alternated with episodes of uncontrollable naughtiness.
- Excessive inhibition in play
- Total inability to tolerate frustration.

- Excessive plaintiveness.

As a result Rita was a serious management problem for her parents.

Erna was 6 years old when referred to Klein and presented the following symptoms:

- Sleeplessness due to night fears of robbers and burglars which alternated with a series of repetitive behaviours (Klein calls them 'obsessional activities' (Klein, 1932 : 65) such as:
  - lying on her face and banging her head on a pillow.
  - making rocking movements whilst sitting and lying on her back.
  - repetitive thumb-sucking.
  - excessive masturbation both at night and during the day, even in the presence of strangers.
  - Tendency to brood (which Klein calls obsessional).
  - Depression with morbid feelings about life.
  - Episodes of over-affectionate attitudes towards mother alternating swiftly with extreme hostility towards her. Her mother was continually 'plagued by her love and hatred' and expressed feelings of 'being swallowed up'.
  - Strong inhibition in learning, incapable of attending school.
  - Precocious sexual development.
  - Paranoid phantasies about mother. (Klein, 1932 : 65-93).

Erna's excessive masturbation, thumb-sucking, rocking, head banging had started between age two and three and Klein makes a retrospective diagnosis of obsessional neurosis as from that age.

Without delving into the ingenious and extremely intuitive psychodynamic elucidation of Klein it is important to determine the basis on which the diagnosis of obsessional neurosis stands. Both Rita and Erna would, according to the multi-axial classification of child psychiatric disorders (Rutter et al, 1973) be diagnosed as suffering from mixed disturbances of emotions. Rita and Erna manifest repetitive, ritualistic behaviours which have a strong compulsive flavour in that they have to be performed even if they interfere with such vital functions as sleep. However, are they typical obsessional symptoms? No true obsessional thinking is reported: neither Rita, nor Erna show truly intrusive thoughts which are insistent, felt as repelling and anxiety provoking and then resisted. Both manifest the signs of early reaction formation (exaggerated goodness) but those are not established with any real degree of permanence since such conscientious and orderly attitudes alternate swiftly with their opposites. Furthermore, are their repetitive and ritualistic behaviour truly compulsive? A compulsion refers to an insistent urge to action which is repellent and needs resisting. A compulsive action also takes place after being resisted by the subject. In both Erna and Rita their repetitive, stereotyped actions do not invite resistance. On the contrary, they appear to be indulged in by both, e.g., Erna masturbated quite shamelessly in front of strangers.

It is undeniable that both exhibit an obsessional type of behaviour and obsessional type of trait but the term obsessional is used herein a loose way and not in the strict way demanded for the diagnosis of obsessional neurosis. This distinction seems important because stereotypical and compulsive behaviour appears in a variety of pathological configurations such as anorexia nervosa, organic

states, depression and yet they are not strictly speaking obsessional. Furthermore, the repetitive behaviour of both Erna and Rita is part of a clinical picture in which other symptoms such as depression, a high level of anxiety, manifest ambivalence and even certain paranoid elements, are present.

In comparison the Rat-Man (Freud, 1909) at age 6 or 7 had the following symptom: a strong wish to see naked women, accompanied by the uncanny feeling that if he allowed himself to think such thoughts something terrible might happen, like the death of his father, followed by the urge to do all sorts of things to prevent the fateful event (Freud, 1909 : 162). Freud considered this isolated symptom to be a prototype of his later illness and judiciously adds: "And if the quality of compulsion was not yet present in the wish, this was because the ego had not yet placed itself in complete opposition to it and did not yet regard it as something foreign to itself" (Freud, 1909 : 162). Yet there was a beginning of opposition in resistance to the urge since it was accompanied by the fear of something terrible happening. This 'prototypical' symptom has all the characteristics of a true obsessional symptom. Rita's and Erna's symptoms on the other hand fail to show the typical obsessional urge.

The question therefore arises: would Rita and Erna have developed a true obsessional neurosis if they had been untreated? It is impossible to answer such a question. But it can be pointed out that there is a tendency in Klein to use the term obsessional in a loose way rather than in a strict way. This view is corroborated by the fact that Klein refers to the repetitive play and the general need for repetition of young children during their anal phase as obsessional symptomatology, when strictly speaking, they are not (Weissman, 1956;

Gesell, 1940; Piaget, 1956; A. Freud, 1965; Sandler and Joffe, 1965). As a result, a certain doubt can be cast on the validity of Klein's sample for the study of obsessional neurosis since it is not evident that they were showing the beginning manifestation of a later obsessional neurosis.

The point just made invites the following reflection. The repetitive, ritualistic, obsessional like behaviours of young normal and neurotic children are the observable manifestations of what Klein has described as obsessional mechanisms. For Klein the obsessional mechanisms, which are basically ego defence mechanisms specific to the anal phase, constitute the core of obsessional neurosis. Leaving the question open as to whether they are or not, Klein would have to explicate their link with the ego-defences typically operating in obsessional neurosis, namely: isolation, doing and undoing, intellectualisation, repression and reaction formation. She does hint at the fact that the typical obsessional neurosis of later adulthood is contingent upon later ego and super-ego development (Klein, 1932(a) : 227) but she does not manage to bridge the gap so as to integrate her theses on obsessional neurosis with those of the classical viewpoint. As a result the contradiction that separates both approaches remains undealt with.

It is not within the scope of such a thesis to attempt an integration of both viewpoints but it seems appropriate at this juncture to elucidate two problems. Firstly, what exactly is the nature of the five obsessional mechanisms which Klein has described and in what way are they different to the obsessional ego-defences as depicted by Freud? Secondly, insofar as the Kleinian obsessional mechanisms are operative during the anal phase of development can they in any

way contribute to the explanation of an anal-sadistic fixation and thus to the broader theory of obsessional neurosis?

#### 6.4 Klein's obsessional mechanisms and Freud's obsessional ego defences

The schizoid defences (Section 4.4.2) comprise idealisation, denial of psychical reality, hallucinatory wish-fulfillment, projective identification and radical splitting of both the object and the ego. They entail the omnipotent denial of psychical reality. The depressive position (Section 4.4.3) is marked by a decrease in projective processes, although they do not cease to operate (Klein, 1940), and an increase in introjective processes. The manic defences (4.4.3) although different to the schizoid defences involve strong denial: denial of dependence on the object, denial of feelings of guilt and mourning, denial that the object is damaged, lost or dead. They equally involve the omnipotent denial of psychical reality.

The obsessional mechanisms as depicted by Klein (1932) are a group of defences which on the one hand operate in close conjunction with the manic defences (Klein, 1940) and simultaneously employ projective processes evident especially in the obsessional control of others. Their aim is to ward off both persecutory and depressive anxieties in the context of an object relationship which is strongly coloured by the now dominant anal component drives. They constitute an attempt to modify the still prevalent early psychotic anxieties of the first year of life. What seems to typify Klein's obsessional mechanisms is the high level of omnipotence and the still strongly operative projective processes which pervade them.

The type of ego which would employ such defences presumably exerts a still tenuous grasp on reality. It relates to objects which are still partial and split, persecutory and ideal, or whole objects which are damaged, feared to be lost owing to the strong ambivalence still operative at the time.

In contrast the type of ego which operates in a typical obsessional neurosis as described by the classical formula shows a true 'double front'. Some of the ego functions and particularly the defence mechanisms of symbolic doing and undoing, isolation, a certain type of intellectualisation and the 'deliria' so aptly depicted by Freud (1909) are regressed, omnipotent and magical in nature. In this context it is particularly interesting to note that Klein acknowledges her debt to Freud's concept of undoing for her own concept of reparation (Klein, 1952 : 227). However, the distinction introduced by the ego-psychologist (Sandler and Joffe, 1965) between the functional and structural aspects of ego (Section 3.6.2) indicate that the regressed ego functioning with its omnipotent quality takes place within the context of an ego structure which is not regressed, which maintains an adequate contact with reality and which is still able to retain a relationship with the object. The object relationship is certainly fraught with ambivalence and a significant proportion of obsessional neurotic symptoms reflect this ambivalence. However, the object is not lost or totally destroyed and felt to be in pieces. This ability of obsessional neurotics to retain their object relationship and an unimpaired reality orientation is usually held responsible for the fact that this particular illness does not lead to suicide in contrast to depressive illness (Freud, 1923(a); Nemiah, 1975).

An important distinction thus appears between the Kleinian depiction of obsessional mechanism and the ego defences operating in obsessional neurosis as depicted by the classical viewpoint. This distinction is intrinsically related to the type of ego structure in which the ego-defences or mechanisms are embedded, and concerns the degree of omnipotent and projective defences employed by the ego in dealing with anxiety. Grinberg (1966) has introduced a valuable distinction between what he calls omnipotent obsessional control and adaptational obsessional control. His distinction is a theoretical attempt to come to terms with the obsessional symptomatology, sometimes extensive, present in borderline patients.

Grinberg refers to the work of Freud and of Klein on obsessional mechanisms in order to establish his distinction: "Obsessional control would be adaptational or omnipotent depending on the quality and intensity with which the mechanisms of projective identification function" (Grinberg, 1966 : 178). Thus if projective identification is strongly operative, the world becomes persecutory, and the subject resorts to omnipotent control. On the other hand, if projective defences are minimally used, it is easier for the subject to establish successful introjects and hence maintain a relatively unimpaired relation with reality, and with the object (Grinberg, 1966).

This distinction is particularly useful because it links with the emphasis placed on the type of ego and its aptitude for using a specific type of defence: omnipotent or adaptational. The distinction between the Kleinian obsessional mechanisms and the Freudian obsessional defences is the degree to which the former are permeated by omnipotent and projective processes. They entail an ego structure which is less integrated. It becomes easier now to understand why the

drive regression hypothesis from the phallic-Oedipal to the anal-sadistic is so central in the classical formula and why obsessional neurosis is depicted as a transference neurosis: obsessional neurosis assumes a relatively unimpaired attainment of the phallic-Oedipal organisation. The ego resorts to a functional regression, a certain degree of omnipotence to modify castration anxiety, but its defences allow it to maintain an adequate contact with reality and retain its object relationship.

On the other hand, if the ego resorts to more omnipotent and projective defences, then its defensive organization is more akin to the obsessional mechanisms as described by Klein. The Kleinian explanation might thus be illuminating in clinical pictures in which strong mechanisms of control are apparent, obsessional or compulsive in nature, and yet failing to show the typical features of an obsessional neurosis. This seems to be the case in borderline patients (Bychowski, 1966; Grinberg, 1966; Joseph, 1966). In Klein's own case, that of Erna, her symptomatology was not typical yet it is undeniable that her repetitive, compulsive-like behaviour was a strong defence mechanism against powerful anxiety situations. As the analysis progressed she manifested extensive paranoid phantasies: " ... she looked upon every step taken in her education and upbringing, even down to the least detail of her clothing, as an act of persecution on the part of her mother ... Moreover she felt herself continually spied on" (Klein, 1932(b) : 77). The paranoid element shows the operation of projective and omnipotent mechanisms as a result of which the world was fraught with persecutory objects. Her uneducability is intrinsically related to the persecutory objects which populated her reality as a result of which introjection was hampered.

In her relationship with her mother, Erna used the mechanism of the 'obsessional coercion of others': good parts and bad parts of the self were projectively identified with a split-up mother, as a result of which she tried to gain control of her good mother by being over-affectionate, or would attack the persecutory mother in a hostile manner. The point made is that Erna was not typically obsessively neurotic because of the omnipotent and projective defence mechanisms employed by her still disharmonious and split ego, an ego unable to maintain an adequate relationship with reality as her paranoid phantasies indicate.

The conclusion which can be derived from the above considerations is that for Klein to convincingly assert that the obsessional mechanisms are the true point of departure of obsessional neurosis, she would have to demonstrate the structural changes that do occur during the anal phase, the transformation in the ego which leads to the type of ego structure and its obsessional defences as described by the classical etiological formula. It seems that such a theoretical task would imply the formulation of an 'anal-Oedipus complex' as a transitory structure between the early Oedipal structure dominated by part-objects and the phallic-Oedipus complex as described by Freud, and leading from the one to the other. In the theoretical conjuncture as it stands at present, Klein fails to integrate her theses on obsessional neurosis with those of the classical viewpoint so that an important contradiction remains between the two theories. Furthermore, the obsessional mechanisms, as described by Klein, account for certain mechanisms of control permeated by omnipotent denial of psychical reality and projective processes. This leads to a clinical picture which is obsessional in nature but does not lead to an

obsessional neurosis. An obsessional neurosis requires other etiological ingredients such as an ego structure which uses more mature defences and a drive structure which has regressed from the phallic-Oedipal to the anal-sadistic fixation points.

#### 6.5 The anal-sadistic fixation and the anal phase.

The anal-sadistic fixation of the drive is an essential element of the classical explanation. However, as such it is inadequately explained. Three sets of explanation are usually put forward in order to account for its occurrence. Firstly, the predisposing biological endowment: the obsessional neurotic would thus be endowed with unusually strong elements of anal erotism and/or sadism. This might well be the case but as such it remains an unproven hypothesis, better held in abeyance since its acceptance or refutation is purely conjectural.

Secondly, traumatic experiences during the anal phase occasioned by a variety of factors such as: real loss, harsh and punitive or indulgent toilet training, defective early interaction between mother and child (A. Freud, 1966; Fenichel, 1946; Rado, 1959), an 'obsessional' family style (Laughlin, 1967; Adams, 1973), a parental empathy deficit (Salzman, 1973; Oai, 1957). These interactional, familial, cultural factors provide an external locus of causation which may well contribute to anal-sadistic fixations. But, as Anna Freud pertinently points out, all those sources of possible trauma are non-specific in the sense that the faulty personality development which may result "can serve equally well as a basis for any other neurotic and psychotic disorder or disturbance of adaptation" (A. Freud, 1966: 119).

A. Freud makes a plea for more specific hypotheses as to the relation between such early experiences and their effect on the intrapsychic

processes typical of obsessional neurosis.

What is interesting about the above two sets of causative factors usually invoked in the psychoanalytic literature, is that they fall outside of the domain which is strictly psychoanalytical, that is, psychical reality. Heredity on the one hand and environmental factors on the other constitute the outer boundaries of the psychoanalytic terrain per se which is the unconscious and structural psychodynamics.

The third factor advanced by the classical viewpoint is the ego's precocity during the anal phase, as a result of which the anal-sadistic phase is prematurely conflictual (Freud, 1926; Nagera, 1976; Sandler and Joffe, 1965). This hypothesis has been investigated in more depth by Sandler and Joffe (1965) who seek in theories of psychological development the perceptual and cognitive style that would predispose the ego to adopt the particular defensive style typical of obsessional neurosis (Section 3.6.2). Such a hypothesis comes closer to a psychoanalytic understanding since it focuses on an important aspect of the psychical structure in its development.

It is tentatively put forward here that, if one avoids a doctrinaire adherence to psychoanalytical factionalism and adopts a more supple eclecticism, then the work of M. Klein is rich in providing properly psychoanalytic explanations of the anal-sadistic fixation. Klein has mapped out the evolution of psychical structures in the first year of life with remarkable precision. Although her theses about the two positions and the early Oedipus Complex are controversial, the application of her theory to the understanding and treatment of psychosis and borderline pathology (Rosenfeld, 1966;

Rey, 1979; Grinberg, 1966) is established and fruitful. Her articulation of obsessional mechanisms, as fully investigated in this present work, helps to locate some of the conflicts which the child has to face on entering the anal phase. Obsessional mechanisms, as a set of manoeuvres employed by the yet fragile ego of the child, operating in close quarters with schizoid and manic defences, warding off persecutory and depressive anxiety within the context of an object relationship dominantly coloured by anal-sadistic strivings, constitute a sophisticated, psychoanalytic description of the type of conflicts which inaugurate the anal-sadistic stage. Even if this psychical structure does not adequately explain obsessional neurosis it paves the way for a better understanding of the anal phase in general and the types of modifications inherent in it. Elaboration of how the obsessional mechanisms and the early anxiety situation still operative contribute to the anal-sadistic fixation would constitute a whole new area of theoretical and practical endeavour.

PART II

CLINICAL STUDY

CHAPTER 7THE CASES OF ALAIN AND ADELE7.1 Aims

In this chapter two of the author's cases are presented so as to illustrate certain features of the controversy which has emerged in the theoretical section.

Case I was diagnosed as an obsessional neurotic. A psychodynamic analysis of the case is undertaken so as to illustrate the usefulness of the classical etiological formula in the clinical context. The major tenets of the formula are used to articulate essential aspects of the internal fabric of the neurosis. An attempt is made to specify the psychodynamic reasons as to why this case was not a severe one, what areas of conflict would have had to have been dealt with in order to enhance development, and what psychological configurations were better left untouched. Thus, alongside a psychodynamic description of the internal fabric of the neurosis, the author emphasises the relevance of psychodynamic understanding both in the diagnostic and psychotherapeutic contexts.

Case II was not diagnosed as an obsessional neurotic although she exhibits extensive obsessional symptomatology. The author will attempt to pinpoint some of the elements of the internal fabric which depart from those outlined by the classical formula, and in terms of which the obsessional symptomatology acquires a different function and meaning. The interest of this case also lies in the fact that

her obsessional tendencies started from a very young age, in early childhood. Her early 'infantile neurosis' is very well documented as a result of early referrals and excellent records. Emphasis is placed on her early symptomatology, and a rapprochement with Klein's young 'obsessional neurotic', Erna (Klein, 1932) is made. The analysis also focuses on the ego-structure in Case II, and the existence of other defence mechanisms employed by such an ego to deal with particular types of psychical conflicts. It is argued that such an ego structure departs significantly from that which usually typifies obsessional neurosis as depicted by the classical formula.

The empirical material used in both cases was obtained from psychiatric interviews, past clinical files and records, and the author's own therapy notes. The therapy notes are either transcripts of video recordings, or notes made after every psychotherapy session. Owing to the abundance of material at the author's disposal the essential features of the history are presented in both case-studies, and relevant material from the therapy notes is introduced as the discussion develops. Owing to the ethical canons of confidentiality some material which may lead to identification is omitted.

CASE I : "The Dogged Archer and his Absent Dog"7.2 Clinical History7.2.1 Presenting Problem

Alain, a 15<sup>7</sup>/<sub>12</sub> year old adolescent, was referred by his parents. 5 weeks prior to referral he had promised himself to stop masturbating, but broke his promise soon afterwards. From that time on, he was plagued by a variety of repetitive, insistent, intrusive ideations which provoked strong feelings of guilt, anxiety and repulsion in him. His attempts to resist them were unsuccessful. He linked his onanistic practices with the appearance of innocuous 'spots' under his left eye. He described his attempts to combat such repellent thoughts in the following terms: "They are not mine ... why me ... my life has become a nightmare". From that time onwards he had been unable to attend school and had become depressed and very insecure. He felt apprehensive about going back to the same school because of what others would think of him. His parents tried to reassure and pacify him but their helpful and understanding attitude did not help.

Obsessional symptoms

Obsessionals have great difficulty giving an exhaustive list of their symptoms. They also find it difficult to give the exact wording or the sequence of their thoughts. The list of obsessional symptoms presented here was obtained both from the initial interview and from the on-going therapy.

- Memories about him and his cousin petting in his parents' bedroom two months prior to onset.
- fleeting sexual thoughts about both his mother and his father.
- thoughts about other boys in the shower, at school, thinking that he is a 'moffie'. When sexually aroused the following ideation would flash through his mind: "This is not for girls ... it is boys you are really attracted to".
- sexual thoughts about his dog.
- memories about various games played with male friends when aged 8 or 9. The imaginary 'butcher game' consisted of cutting up pieces of sausage (boerewors) with the butcher's knife and playing at having the 'longest one' between their legs. The other game was a mimic of sexual intercourse in which the protagonists would make their buttocks tight, 'like a woman's', and alternate between the male and female position.
- whilst playing golf, he chipped a tuft of grass and the memory of a cat killed by a dog in his early childhood was re-evoked, with the accompanying guilt laden thought: "You killed the cat ... you burned it alive ... you're a murderer".
- if he inattentively broke a twig off a tree, similar thoughts about being a murderer would at times assail him.
- whilst tapping his hand on a table or his feet on the floor he would have the disturbing thought that the table or the floor was cracked open.

Prior to onset he had had two episodes of obsessional behaviours, which later stopped. A hand-washing ritual, and a checking ritual. He checked five times, every night, that his bedroom door was closed so that the neighbour's dog would not come and mess in his room.

#### Prior medical and psychiatric history

Alain has always been in excellent physical condition. Between the age of 4 and 6 he suffered from sleep disturbance due to nightmares. The content of his nightmares was dominantly about war, soldiers, pistols and water-pistols which he had, and a frightening man on the ceiling who would shout at him.

At age 6 Alain was involved in two very minor accidents. In the first one a car hurt him very slightly, and he felt very anxious and guilty about having caused his parents to worry about him. The second accident occurred when his father's car, driven by his father, had a very slight collision with a bus. Alain reacted to this incident with enormous guilt and anxiety: "Dad, your car is finished ... it's all my fault".

At age 9 his father was fixing a garden tap and made a mistake which led to water sprouting from the tap. Alain was panicky, and extremely anxious and was scared that his family would die due to lack of water. Around that time he felt extremely insecure, and feared the death of his parents whenever they went out without him. He became clingy and demanding. He was referred to a clinical psychologist, was psychometrically assessed and had 6 play therapy sessions. His anxiety abated considerably. Psychometric assessment showed

above average intelligence and the thematic apperception test revealed "classical oedipal problems".

### Family history

Alain is the youngest in a 3-sibling family. His father, in his fifties, is a hard-working man, devoted to his family, and has no higher education. Father nearly died of viral encephalitis when Alain was 6, shortly after the car accident. Father lost consciousness whilst watering the garden with a hose from the tap. No psychiatric history in paternal family. His mother, in her early fifties, is a housewife and admits to a high regard for cleanliness and order in the house. Her father was an alcoholic, suffered from depressive illness and committed suicide. Alain's two elder sisters are well adjusted and good students. The family experienced initial material hardships but now live in middle-class comfort. Both parents claim a satisfactory marriage and no child favouritism. Alain has always been close to both of them and an affectionate child. Both fully accept his leanings towards becoming a professional sportsman.

### Personal history

Normal pregnancy and birth - planned child - normal developmental milestones - unproblematic toilet-training at age 2½ - no feeding problems - nightwalking up to present - some difficulty separating from mother when he started school - average pupil, not very academically oriented, passed all his classes - excellent sportsman.

Personality: amiable personality; always readily displayed his emotions; since age 10/11 has started playing lots of sport (cricket, golf, archery) and his main ambition is to become a professional; respected at school for his sporting prowess.

Mental State Examination: a good looking, tall adolescent, well kempt - no psychotic symptomatology - worried, anxious and depressed about his condition - sensorium intact - no understanding of his problem - good reality orientation.

Treatment: tricyclic antidepressants for depression which remitted very soon.

: family interview and parental counselling.

: 46 x 1 hours individual psychotherapy.

Two and a half years after termination Alain is coping well. He has passed his matriculation examination and is now undergoing military service. He has felt no need to contact the psychologist since therapy stopped.

### 7.3 Psychodynamic Analysis

#### 7.3.1 Onset and the infantile neurosis

Alain's integrated obsessional neurosis appeared only when he was fifteen years old. It was clearly contingent on his conflicts over masturbation and sexuality. However, his present problem was preceded by various anxieties which appeared between age 4 and 6 and culminated, at age 9, in his first referral. He was already then irrationally anxious about his parents' death, or about the possible death of his family. He had an agitated nocturnal dream-life whose

contents were aggressive in nature, and an overdeveloped sense that he could cause harm to others (the two accidents). The psychiatric history and close questioning of both parents reveals no disturbance prior to age 4. Parental reports about their children at an early age are not strictly reliable but, as a second best source of information, they indicate that there was nothing really disturbing in Alain's behaviour prior to age four.

The term infantile neurosis is here used in its Freudian sense to refer to the neurotic outcome of the Oedipus Complex (refer to Section 3.9). Alain's present obsessional neurosis was preceded by a neurotic organization whose formation can be traced, with a fair degree of clarity, to his Oedipal phase. His nightmares started at age 4 and at the age of 6 he was already prone to irrational anxieties. The rooting of his problems in the Oedipal phase is corroborated by the fact that projective testing at age 9 revealed "classical Oedipal problems" according to the clinician's report. It is thus contended that Alain's adolescent obsessional neurosis was preceded by a neurotic organization, accompanied by overt symptomatology with no clearly identifiable form as yet, which was an outcome of his problematic and conflictual Oedipus Complex. In other words, Alain's clinical picture fits in with the classical formula's emphasis on the crucial role played by the Oedipus Complex in obsessional neurosis and the post-Oedipal onset of the neurosis.

A psychodynamic reconstruction of the main elements of this infantile neurosis, and its relation with the later obsessional neurosis, will be attempted.

At the age of 6, Alain's reaction to two situations which could

have led to him being physically hurt (the two accidents) was to become irrationally anxious at having caused his parents to worry, and to blame himself for having caused irreparable damage to his father's car. In other words, the anxiety of being hurt was accompanied and complicated by an even more powerful anxiety of having caused irreparable damage to his parents, and his father in particular. This already neurotic scenario suggests a strongly operative fear of harming others, that is, a fear of his own aggressivity, and the presence of a deep sense of guilt or of harsh and severe super-ego introjects already active in his personality. Being potentially hurt thus led to the fear of an internal part of his personality, and to aggression turned against the ego "It's all my fault, I've hurt you".

This reconstruction is supported by the fact that in his latency phase Alain was scared of the death of his parents, that is, of something terrible happening to them. Furthermore, the main themes of his anxiety provoking dreams were war, destruction, destructive weapons such as a pistol, and more particularly a water pistol. A prominent element in his nightmares was the threatening, destructive figure bent on causing him harm. It can thus be posited that Alain's Oedipal difficulties resulted in a deep sense of guilt, a severe super-ego, and anxiety at his own destructive urges, which, he felt, were able to cause the death of those very people he loved the most, his parents, and more particularly his father. The fear of something terrible happening to them was already a distorted representation of his own destructive wishes against them, a compromise formation between his unconscious aggressive wishes and a conscious sense of responsibility which was exaggerated. One is reminded of Freud's own writings on the theme of death in obsessional neurosis: "But these neurotics need

the help of the possibility of death chiefly in order that it may act as a solution of conflicts they have left unsolved" (Freud, 1909 : 236).

Alain's father nearly died one month after Alain was so anxious at having caused irreparable damage to his car. This real event obviously played an important role in Alain's psychical reality and perhaps reinforced his own sense of guilt and fear of his ability to cause harm. A closer scrutiny of the circumstances of father's illness and how they relate to Alain's anxiety yields an even more precise reconstruction of the unconscious phantasies operating at the time.

Alain's father had his first symptoms of encephalitis whilst watering the garden. One of the aggressive symbols in his nightmares was the water-pistol. At age 9, Alain became irrationally anxious about his family dying as a result of the lack of water. His neurotic anxiety was fed by the real fact that there was a drought in the town where he resided at the time. This specific anxiety at the possible death of his loved ones was triggered off by the sight of his father fixing the garden tap, and owing to a mechanical mistake, not being able to stop the jet of water from the tap. It is evident that this conscious discourse is sustained by a latent text in which three signifiers play a crucial role: tap/pistol, water, and death. In other words, at the level of unconscious phantasy Alain had a deep fear that part of him, from which sprouted a liquid substance, could cause death. This construction is supported by a wealth of phantasies which appeared in therapy about rain, or poisonous substances leaking from plants, and causing the death of his family. The failure of his Oedipus Complex resulted in the unconscious image of a dangerous

penis (a regressed, anal penis?) which can do harm, and in the harsh super-ego introject which manifested as an exaggerated sense of guilt.

In summary, it can be said that Alain's adolescent neurosis was preceded by an infantile neurosis whose onset is traceable to the time of his Oedipus Complex. The failure of the Oedipus Complex is already marked by anxieties at his own aggressive urges, centred around the unconscious representative of a dangerous penis. In his latency phase there is as yet no obsessional neurotic formation, although elements of the later obsessional neurosis - a harsh super-ego, prominence of the theme of death - are present.

### 7.3.2 The drive regression and the overall clinical picture

It is evident that Alain's sexuality constitutes the important focus of his adolescent neurosis. His failure to keep his promise about putting an end to masturbation is the crucial precipitating factor in the outbreak of his neurosis. Masturbation was associated with 'badness' and abundant guilt. It was equally associated with dirt as he himself magically linked his sexual practices to spots under his left eye, that is, to impurities. Intrapsychic conflicts made it impossible for Alain to fulfill the genital demands of his sexuality, which is equivalent to saying that there was a failure in the constitution of his genital organization. The aim of this section is to determine the extent of his failure to do so, and the main elements of his psycho-sexual definition.

Alain had been masturbating for two years, and even though he had at times felt the compulsion to wash his hands, there were positive elements to his masturbation. He thus spoke about his ability

to ejaculate as a constructive proof of his masculinity: one day he would have a family and babies. This 'good' aspect of his genital sexuality was important for his masculine psycho-sexual identity. Two months before onset, however, his erotic encounter with his cousin in his parents' bedroom led to anxiety and guilt. Incidentally, he still sleep walked to his parents' bedroom when he had frightening dreams with an aggressive content. His first sexual encounter, whose memory was to reappear in obsessional form two months later, had a distinctly Oedipal and incestuous character about it. His partner was a cousin, a person close to the tabooed object of Oedipal desire, and the site of his erotic encounter was his parents' bedroom, that is, the place par excellence of the primal scene, and whatever this prototypical phantasy scenario evoked in him.

Alain's accession to genital heterosexuality was thus impaired since his discovery of genital sexuality led to an obsessional neurosis. Freud's usage of the Jungian concept of introversion in neurosis is useful at this juncture: Alain's attempt at cathecting a heterosexual object was marred by conflicts which led to a withdrawal of his libido from the external object, and the cathexis of imaginary psychical objects or phantasies. Alain lived his sexuality through his symptoms, and, if his symptoms are given the audience they deserve, they constitute the royal road to an understanding of his drive constitution and facilitate an assessment of the degree of failure in his genital organization.

Alain's symptoms speak poignantly about a variety of themes which provoked deep insecurities in him. One dominant theme is that of sexual ambivalence, which points to an indecisive admixture

of both masculine and feminine identifications as a result of his Oedipus Complex. Alain's sexual obsessions were both about his mother and his father. His sexuality was still fixated on both the Oedipal maternal and paternal objects. Furthermore, his attempts at cathecting a heterosexual object were marred by his grave insecurity about his masculinity. His obsessions about being a 'moffie', his anxiety about being 'really attracted to men', and his obsession about his earlier homosexual game with friends in which they enacted both the male and female protagonists of coitus (per anum), point to his inability to resolve his sexual ambivalence and his sexual identity confusion. Psycho-sexually Alain had regressed to a pre-Oedipal phase of sexual development and exhibited the ambivalence which is associated with the anal phase (Section 3.3.5).

Another theme which runs through his obsessions is that of his strong ambivalence between love and aggression. Alain's infantile neurosis already showed signs of severe conflicts over his destructive urges. Many of his obsessions are about the fear of his own destructive ability displaced onto trifles. Thus breaking a twig evoked in him fears of being a criminal. His spectacular obsession about hurting the grass = burying the cat alive led to feelings of being a murderer. At the level of phantasy, tapping the table or the floor could lead to giant cracks. This fear in the omnipotence of his own destructive urges was equally evident in his dream life. Alain discovered in the course of therapy that an increase in his obsessional concerns was associated with the dreams he had the night before. Many of his dreams were repetitive and had to do with epidemics, illness, and floods, that is, large scale death. The epidemic was often indistinct but on two occasions he spoke about leakage from

a poisonous factory ('imagine', he said, 'you press one single button and this happens', showing the fears of his own omnipotence), and about massive floods around his school (the same school where, in another dream, he caned the headmaster). In those dreams it was his heroic task to restore the situation which he invariably came short of doing. At the level of unconscious phantasy Alain believed in the omnipotence of his own aggressive urges and had doubts about his ability to repair the damage done.

Thus if Alain still had erotic wishes on both his parents he equally felt incredibly destructive towards both of them. His libidinal relations were marred by his destructive wishes showing the characteristic defusion of the drive (Section 3.3.6). This ambivalent attitude towards the object of desire is illustrated by an anecdote about his attempts to approach a girl he was attracted to: he himself sabotaged his courting her by placing a pubic hair in her hand, thereby revealing the aggressive character of his sexuality.

Alain's sexual ambivalence and his deep conflicts over love and hate are both typical indices of a regression from the phallic-Oedipal organization to the anal-sadistic fixation. Oedipal phantasy objects clearly dominate his sexuality, and the presence of both the negative and positive Oedipal themes, and the conflicts over love and hate, point to the regressive analisation of his Oedipal strivings.

Further evidence of the regression to the anal-sadistic organization is obtained from the rich, and symbolic material which permeates the clinical picture.

### 7.3,3 Anal-sadistic symbolism

Water - its abundance or penury, toxic substances, and epidemics feature prominently in Alain's phantasy life. During the anal-sadistic phase of development, urine, a substance which can flood, and the faeces, a dangerous toxic substance, are vehicles of urethral and anal sadism which can do irreparable damage to the love-object. Water and dangerous substances, leading to mass-scale death, are symbolic expressions of both the urethral and anal-sadistic drive trends still prominent in Alain's regressed drive organization.

Alain was an excellent archer, the best in his age category, and he was destined to become a champion and wear the national colours. Whenever he spoke about archery his eyes would glow with pride and his description of the act of shooting had an unmistakable aesthetic and sensual quality. He took meticulous care in cleaning his bows and arrows: "there must not be a single spot on them. In this regard I'm like my mother". No arrows were good enough for Alain: he wanted the best, especially ordered from overseas.

Alain's interest in archery started during his latency phase, at the time he was showing the symptoms of his infantile neurosis. Whilst on holiday he accompanied his mother to the cinema. The theme he remembered was classical: a prince in love with a princess who belonged to the enemy camp. The prince ordered his men to attack the fortress so as to free his beloved. Alain's description of the "thousands of arrows that flew across the sky", and his onomatopoeic account of arrows "piercing the guy's neck", expressed an unmistakable admixture of sensual pleasure and sadism. The classical Oedipal theme

of the chivalrous prince who liberates the trapped princess from her foes was pervaded by a high level of pleasurable violence, a further index of the regressive analisation of his Oedipal strivings.

Arrows, pointed objects, have a distinctly phallic quality about them. Within the Oedipal structure, to be endowed with the penis is to be endowed with a narcissistically valued object which can satisfy the mother's desire. However, Alain's penis is not simply a good penis, it is also one with fantastic destructive qualities.

It is in fact a regressed anal-penis which can kill and do harm.

Arrows can thus be seen as a symbolic representative of the destructive faeces which in the child's imagination can be used as projectiles. At the level of Alain's unconscious, a symbolic equivalence obtains between the arrows that fly across the sky, rain which can flood, and dangerous substances which leak from the plant. They are all metaphors for 'bad bodily products' which refer directly to the prominence of anal and urethral sadistic trends in his sexuality.

The anal origin of his passion for arrows appeared again in his fascination for William Tell. Tell had the ability to split an arrow with another from behind. Alain portrayed this feat with a hand mimic: one finger of his right hand penetrating his tightly clenched left hand and "it opens up like the tail of a pineapple". It is difficult to render the intense aesthetic satisfaction manifest in his expression when telling and miming the exploits of Tell. To the author, however, it was apparent that Alain was expressing a secret pleasure unknown to himself: that of coitus per anum, a theme which reappeared in obsessional form in the context of his homosexual childhood play.

The inverted Oedipus Complex can be understood as a phantasy structure in which the anal introjection of the penis is central (Grunberger, 1966). This phantasy is prominent in the spectacular obsession with the rat torture in Freud's Rat-Man (Freud, 1909). In Alain's case there is evidence, owing to the regression from the phallic-Oedipal organization, of an inverted Oedipal structure which can be seen to be at the root of his homosexual tendencies, and which caused him great difficulties at the conscious level of his obsessional ideas.

Freud's famous equation between "faeces-gift-money-penis-baby" (Section 3.3.4) would have to be modified in Alain's case so as to include 'urine-faeces-water-arrows-penis'. The Oedipal penis, owing to regression, on the one hand, had acquired the destructive qualities of projectiles, and, on the other hand, referred to the problematic presence of his inverted Oedipus Complex and his homosexual tendencies which he was attempting to come to terms with. Another signifier, that of the dog, played an important role in Alain's psychical life and points to his anal-sadistic regression.

#### 7.3.4 The rescuer: the sausage dog in green and gold

In the obsession about the 'butcher game' the anal penis (the sausage) is distinct. Alain wanted to have a dog during his childhood, but this wish was not fulfilled owing to his mother's obsessional concern with cleanliness. Alain's checking ritual concerned the fear of a dog entering his room and making a mess. Alain's father was concerned about his son's disturbed sleep at night, and would at times come to see whether he was still in his bed; Alain, in his

sleep, had told him: "Dad, what are you doing with the dustbin lid on your head?" At the time of his neurotic breakdown Alain was writing a natural study on dogs. One of his disturbing obsessional ideas was that of the dog which had killed a cat. Alain's guilt feelings about having killed the cat points to an identification with the criminal dog. Furthermore, Alain had obsessional thoughts concerning intercourse with dogs.

In one of his dreams an epidemic threatened his family. His rescuing mission was to run to town and get a dog. He did go to town but failed to reach the dog. More precisely, the dog was a sausage dog and was dressed in green and gold. Green and gold were the favourite colours of his mother but green and gold are equally the national sporting colours which many a young South African male covets to wear one day. The sausage dog inside Alain's favourite colours, which happened to be his mother's favourite colours, can be seen as a cryptic formula of the anal penis inside the maternal object, in other words, a metaphoric representation of his inverted Oedipus Complex.

Furthermore, this dream particularly perturbed him since his rescuing or reparative attempts were thwarted: he failed to reach the dog which would have saved his family from the impending threat of death. The dog was an expression both of Alain's anal-sadistic fixation and of his deep wish and desire to be well. It referred both to the anal destructiveness inherent in his sexual definition and to the procreative, reparative good penis. However, the good penis-dog was still ... absent.

The material presented in the previous paragraphs shows evidence

of the regressive analisation of Alain's Oedipus Complex, and provide an in-depth view into the unconscious conflicts which were causing him so much anxiety and insecurity as a young adolescent.

#### The extensiveness of the regression

Despite the drive regression to the anal-sadistic organization Alain's genital strivings were still active. He still masturbated and, as therapy progressed, with less guilt. Furthermore, his heterosexual tendencies were strong and, although he was insecure about his masculine position, Alain made a good deal of progress in attempting to court girls. In therapy he was able to come to terms with his anger towards both his parents and his guilt about his own destructive wishes against them diminished considerably. Alain was able to gain more trust in the good parts of his personality and accept that his bad parts did not magically lead to death. The potential for a more integrated genital organization was on the whole good despite the fact that Alain's problems were not fully dealt with.

The survival of a significant part of his genital organization was an important prognostic factor. However, other factors equally account for the fact that Alain's obsessional neurosis was not a severe one. More specifically, a specific outcome of the regression will be dealt with.

#### 7.3.5 The sublimation of his anal-sadistic libido

Sports in general played an important role in Alain's life.

He spent up to four hours a day practising and his talents won him a great deal of recognition amongst his peers at school.

Archery, more specifically, exerted a fascination on Alain, and his premature excellence at it augured well for his future sporting career. The anal-sadistic meaning of archery has been demonstrated. Archery thus constituted a proper sublimation of his anal-sadistic strivings. It is advanced that this particular factor played an important role in accounting for the mildness of Alain's neurosis.

If an economic approach is adopted as regards the distribution of Alain's libido, a significant proportion of his anal-sadistic libido had found expression in an activity, owing to sublimation, which was ego-syntonic and narcissistically strengthening. Had his anal-sadistic libido been totally dystonic with the ego, the defensive conflict would have been more intense. Instead this highly successful sublimation had led to an identification which gave the ego strength, and helped a great deal in his masculine psycho-sexual definition. If the sublimation had been unsuccessful it can be expected that Alain's ego would have been mobilised in a more severe defensive conflict and hence his growth more impaired. Utmost care was taken in therapy not to upset or interpret this sublimation. In fact his interests in sport were never put in doubt and always warmly accepted. The beneficial gains from this successful sublimation invite a discussion of the role of sports in general in Alain's neurosis.

#### 7.3.6 The status of sports in Alain's psychical life

Obsessional ideations dominated Alain's symptomatology. Compulsive

rituals or obsessional ruminations were markedly absent. However, Alain resorted to physical activity in order to ward off his obsessions and at times would play sports in a conscious attempt to reinforce his good feelings about himself. His immersion in sporting activities started at age 10/11, more especially after his sisters had criticised him for being 'fat', which he never really was. Since then he had undertaken a rigorous programme in the gymnasium to develop 'big muscles'. It is suggested that Alain's hypersensitivity to being 'fat' was in fact a way of dealing with the 'impurities' in his character. Although sports do not fit the strict definition of compulsive behaviour, and are very different to the ritualistic behaviour evident in obsessional neurosis, sports in Alain's life had a similar function. It will be argued that sports functioned as a protective measure (Section 3.1.2) and played the same role, with a less crippling effect, that obsessional ruminations do in obsessional neurosis.

Freud had described the fate of protective measures (Section 3.1.2): they eventually become substitutes for the very primary symptoms against which they were erected. Thus thinking can become sexualised. One disturbing element of Alain's neurosis was that it had led to a temporary cessation of his sporting activities. He had lost an archery competition because his obsessions interfered with his shooting. In the course of playing golf he had started to think that he had no right to 'enjoy himself'. Whilst hitting the ball he at times felt that the shot might cause the death of somebody. There were signs, in other words, that sports, as a protective measure, were becoming a substitute for the satisfaction of proscribed wishes and urges. The association between sports and 'enjoying oneself' had

the connotation of an equivalence between sports and masturbatory practices. It would have been disastrous if one of the most important and strengthening aspect of his ego's defences had become permeated, and thus inhibited, by the prohibited id urges. This process did not take place and on the whole Alain resumed his activities successfully during the course of therapy. One notable change did take place during those 7 months: an increased interest in boxing at the expense of archery!

### 7.3.7 The ego, its strengths and defences

Alain's neurosis did not stem from the soil of an anankastic personality. He showed a certain degree of reaction-formation in the form of perfectionism, and a certain docility and amiability which covered up the more aggressive parts of his personality. But his perfectionism was limited to sports. He was quite satisfied with his average performance at school and, his family's accepting attitude helping, did not experience severe guilt about it. He found the expression of negative affect very difficult to start with, but, with the help of therapy, which included parental counselling, was able to assert himself increasingly vis-a-vis his obsessional mother and his father.

The most prominent ego defence mechanism was that of isolation of thought from thought, and of affect from thought. The full symptomatology presented in the psychiatric history was obtained over a seven-month period. He still had difficulties speaking about the content of some of his thoughts and accepting the links the therapist

attempted to make. The extensive usage of isolation of thought from thought gave Alain the 'slippery' character (Salzman, 1973) typical of obsessionals. On the other hand, Alain would at times speak about the most violent or destructive phantasy without a trace of affect and in complete oblivion of the obvious link between those phantasies and his obsessions. There was no typical bi-phasic symptomatology which illustrates the mechanism of doing and undoing. His reparative tendencies expressed themselves rather in his compliant attitude to mother's exaggerated demands for order, and a general amiability which covered up the aggressive parts of his self.

Alain's ego was on the whole well-integrated. There was no sign of a poor orientation to reality. Neither were there any signs of his ego having to resort to more 'psychotic' defences in order to cope with his anxiety. His ego-structure (Section 3.6,1) was intact. The functional aspect of his ego showed a measure of regression in that some of his thinking process was archaic and omnipotent in nature. However, Alain's thinking was on the whole not dominated by obsessional thinking, which usually exerts such a crippling effect on the functioning of the obsessional. Alain's thinking, in comparison, was free from interminable discussions about good and evil, life and death, or religion, as usually is the case. The extent of functional regression of the ego was thus minimal.

#### 7.3.8 The super-ego

Alain suffered from an exaggerated sense of guilt. Already in his infantile neurosis there were signs of harsh super-ego introjects operating, and he was extremely anxious about his own aggressive

urges construed in an omnipotent way. However, the primitiveness of a part of his super-ego was counterbalanced by the establishment of mature and successful ego-ideals. More especially his identity as a sportsman gave great strength to his ego and his ego-ideals were not discrepant with his ego potential: he could fulfill them in real life. They thus fulfilled an important pacifying role, and provided him with a helpful and benevolent programme of future ontological realisation, which gave him a sense of worth, and respect amongst his peers, and helped considerably in his masculine psycho-sexual definition. The degree of super-ego regression was not severe.

#### Summary

Alain's obsessional constellation was diagnosed as a typical obsessional neurosis using both the criteria of descriptive psychiatry (I.C.D. 9, 1978) and the 'classical etiological formula' so as to assess the intrapsychic elements of the clinical picture. Furthermore, the mildness of his obsessional neurosis was accounted for in terms of a variety of factors such as: the onset of his problems in the Oedipal phase of development, the intactness of a fair proportion of his genital libidinal organizations, the ego structure which showed an unimpaired orientation to reality, the limited functional regression of the ego, the successful usage of 'adaptational' obsessional defences and the absence of more 'psychotic' defences, and finally a super-ego which showed a good degree of successful and mature introjects.

It is clear that Alain's fixations were anal-sadistic in nature although a healthy part of his genital organization had survived the

regression. There was no evidence of an oral fixation. His present sexual identity problems can be understood as a result of this anal-sadistic fixation, and particular emphasis has been placed on showing the existence of his negative Oedipus Complex. It could be expected that in the future Alain might have problems in establishing a secure masculine identity. But on the whole, since his obsessional neurosis is clearly identifiable as a transference neurosis, he is a candidate who can be helped by psychotherapy.

#### 7.4 CASE II "Adele's Lament : "My-Mother-My-Self"

Adele was referred to the author for her pervasive feelings of insecurity about her life in general, her anxiety at not coping with her course of studies, occasional feelings of depression, and a fear of breaking down again. Her psychiatric history is complex and severe. She was seen by the author for 60 x 1-hour sessions over a period of seven months. The intervention was essentially supportive in nature. This particular choice of treatment was dictated by the complexity of the case and the clinician's awareness of his own limitations and lack of skills in the face of her psychopathology.

The aims of treatment were to assist to contain at times of stress, and to attempt to strengthen and reinforce certain positive aspects of Adele's precarious ego. As a consequence, however, the elucidation of aspects of her case will lack the psychodynamic richness of Case I. Particular emphasis will be placed on the development of her extensive obsessional symptomatology, the ego and super-ego structures and the other defence mechanisms employed by the ego.

##### 7.4.1 Essential features of the psychiatric history

Adele is a 24-year old, unmarried woman, involved in a stressful course of studies, with the aim of qualifying as a 'helping professional'.

Family history: Seventh child of a nine-sibling family. Father suffers from manic-depressive illness. One elder sibling, equally depressed, committed suicide when Adele was adolescent.

Adele's relationship to her mother has always been very ambivalent. The family has known many stresses owing to father's illness. The family style is chaotic and inconsistent.

### Psychiatric referrals

(i) Adele was referred to a child clinic at age 3½. Excellent records reveal the following problems:

- extreme irritability, restlessness, uncontrollable tantrums, and poor frustration tolerance which mother could not manage.
- severe separation anxiety from mother, extreme fearfulness of strangers, demanding and clinging child.
- excessive masturbation using fist or piece of furniture, in any context, and in front of strangers. As an adult Adele remembers her early onanism: "I would get so tense and angry ... I had to do it".
- repetitive twisting of her hair and repetitive pulling in of her cheeks.
- food faddiness.

At age 2<sup>9</sup>/<sub>12</sub> Adele and her younger sibling were separated from the family for a 3-week period and placed in a home. The family at the time was under stress: mother had just given birth to last sibling and father was ill. Adele reacted to the separation by not eating for three days, and by clinging to her baby sibling. When back home Adele was "very quiet, stood with her mouth open, twisting her hair".

She was then treated with minor tranquillizers and play therapy (2 x weekly) over 6 months. The material which emerged in therapy will be presented in the discussion.

(ii) At age 5, when she started school, she was referred to the same clinic. She presented with the following complaints:

- she became 'hysterical' when reading with mother.
- she alternated between a loving and very hostile relation to mother and was equally excessively hostile to another girl living in the house.
- she had cut herself off from all the other siblings except the two younger ones.
- she had new manneristic, repetitive behaviours everyday.
- a marked tendency towards obsessional brooding.  
She thought about abstract topics such as 'relationships' until she felt 'exhausted' without ever coming to a resolution.
- a tendency to be perfectionistic, controlling and demanding of others.
- only her father could take her to school.

Treatment - a divergent squint was diagnosed and Adele underwent surgical intervention.

(iii) At age 9, Adele was referred for a third time for:

- daily 'hysterical' outbursts directed at mother who she

blamed if anything went wrong.

- depressive ideations such as feeling unloved by her mother and wishing she was dead.
- very perfectionist tendencies: she felt very responsible for her two younger siblings whom she took to school, and was exacting and demanding.
- ritualistic behaviour: her school clothes had to be ready and placed on her bed before she went to sleep. It had to be the same shirt, with the same buttons. She kept her room and wardrobe in strict orderly fashion. There was only one drawer in which she could be 'messy'.
- obsessional brooding: she had to think about abstract topics which isolated her from her peers at school.

Treatment : Psychometric assessment showed an average IQ. Adele was extremely anxious in performance situations. Her draw-a-person test shows a meticulous concern for detail and the clinician made a special remark about her marked 'obsessive compulsive tendencies'.

Adele performed better in high school and obtained a first-class matric pass. Her adolescence was fraught with social difficulties and anxieties. She experienced mood fluctuations. When neither withdrawn nor euphoric and overactive, she was very controlled and had great difficulty expressing her feelings. She was often pre-occupied with thoughts about the past and replays of recent events. At age 15 she was depressed over a four-month period. One year after matriculating she registered for the present course of studies.

She always had difficulties coping with the course because of her anxiety and perfectionism. At age 19 she consulted a psychotherapist for one year and therapy aimed at loosening her controls and affective expression.

At age 20 she could no longer cope with her studies and was referred to a day hospital for a 4-month period. She presented with the following problems:

- increasing anxiety at work and inability to see her patients.
- feeling lifeless, as if 'she had lost part of herself', anhedonic and withdrawn.
- bizarre sensations in her head for past 4 months, as if "her brain had separated into 2 halves which were pulling".
- frightening experiences when she smoked cannabis.
- worried about everything and obsessional writing down in a book, meticulous planning of all her activities. Meticulous rehearsing of future situations so as not to forget. Her mind was crowded by repetitive, ruminative thoughts which she could not resist. Compulsive checking that doors were closed and that she had all her possessions.

Her Mental State Examination revealed no formal thought disorder, no hallucinations or delusions. Her sensorium was intact. She expressed her deep insecurities as follows: "I have no firm core, I don't know who I am".

Treatment - Temporal lobe epilepsy was queried but evidence was

insufficient. Individual and milieu therapy were attempted but her involvement in the ward was peripheral. She was diagnosed as a cyclothymic personality disorder.

(iv) On discharge Adele resumed psychotherapy. Seven months later she was hospitalised in a psychotic state with formal thought disorder, auditory hallucinations and delusions of omnipotence. Schizophrenia was queried but she was diagnosed as manic-depressive and treated accordingly. She spent 4 months in a psychiatric institution.

She resumed her course of study the following year and attended an out-patient service for maintenance therapy. Eighteen months later she was referred to the author and supportive therapy was recommended.

(v) Adele experienced great difficulties coping with life in general. She felt very insecure, was not psychiatrically depressed, nor did she show any overt psychotic symptoms. She alternated between episodes of feeling euphoric and very active and episodes of feeling very anxious, unable to function. She attempted to achieve control over her life, activities and mood in a variety of obsessional ways.

- meticulous planning of her day, of the week and various aspects of her life. Everything had to be written in a book as she could not trust her memory.
- compulsive rehearsal for her work activities and she left no room for spontaneity.

- obsessional concern for order: her waking up was planned and if any extraneous event disrupted the sequence of bathing, dressing, or having breakfast she would feel extremely anxious.
- her room was immaculately clean and everything had its place.
- extreme perfectionism: her excellent actual performance was never good enough.
- preoccupation with ruminative thoughts about her interactions, her work, relationships with the characteristic inconclusiveness.
- extreme caution about her bodily health.

## 7.5 Discussion and Psychodynamic Evaluation

It is clear that Adele is not and has never been an obsessional neurotic. However, from a very young age she has shown extensive obsessional symptoms and features in the form of strong reaction formations, a tendency towards rumination and intellectualisation, and a definite and extensive compulsive attitude in many of her activities. The following discussion will focus on various aspects of her obsessionalism, its development and its role within her clinical picture.

### 7.5.1 Early childhood 'obsessions' : Adele, Erna and Alain

The similarity between Adele and Erna's early childhood symptomatology is striking. Both, by the age of 5, had shown more or less the same range of symptoms, namely: compulsive masturbation, repetitive ritualistic behaviour, desire for sameness, a tendency to brood

and early intellectualisations, a very ambivalent relationship towards their mothers, depressive ideations and a coercive control of others. Erna and Rita were two of the cases on which Klein built her particular viewpoint on obsessional neurosis. She diagnosed both of them as obsessional neurotics from the young age of 2 (Section 6.3). Using the same criteria as Klein did, and these criteria have been criticised for their lack of rigour (Section 6.3), Adele could be diagnosed as an obsessional neurotic from the age of 3½ owing to the presence of her early compulsive type of symptomatology. Yet Adele never developed an adult obsessional neurosis.

The relation between childhood and adult symptomatology is a complex one and problems of prediction abound (A. Freud, 1965, 1970). What is perhaps unique about obsessional neurosis is that its childhood form, usually observed after the age of 5 onwards, is homologous to its adult form (Rapoport et al, 1981). If strict logical criteria are observed it is not valid to argue that the similarity between Adele and Erna's early symptomatology disproves Klein's views on early childhood obsessional neurosis. Despite the similarity between their early clinical pictures, Adele could have been showing very different intrapsychic conflicts to Erna, given the fact that the same early childhood symptom can have very different psychodynamic valencies (A. Freud, 1970). However, Adele's case casts doubt as to the validity of making any predictions on the basis of pre-Oedipal symptoms which have an obsessional quality and which, according to Klein, indicate the prominence of obsessional defences employed by the young ego. If Adele, at 3 years, was using obsessional mechanisms to defend against her considerable anxieties, it was not a sign that an obsessional neurosis was developing and no future prediction could be made on that basis.

The case of Adele, in fact, tends to support Anna Freud's opinion (A. Freud, 1965), that early obsessional controls, if prominent at an early age, are signs of ominous splits and fundamental disharmonies in the ego.

At this juncture it is interesting to compare Adele and Alain's childhood symptoms. Adele showed obsessional tendencies at a much earlier age than Alain. Alain's pre-Oedipal phase showed no signs of conflict worthy of mention by the parents. His anxiety symptoms first appeared in the latency phase and his obsessional neurosis only emerged fully at the age of 15. A tentative hypothesis is thus suggested by this comparison: the severity of obsessional configurations may be related to the age at which they make their appearance. More specifically, pre-Oedipal obsessional or compulsive configurations are more ominous predictors of adult psychopathology than a clearly post-Oedipal onset. Such a hypothesis, however, could only be confirmed by considering a much larger sample of obsessional patients.

Adele's obsessional configuration played an important role in her psychical make-up. It was one of the defensive manoeuvres employed by her ego in dealing with her severe conflicts. The remaining part of the discussion will attempt to specify the nature of those conflicts, the other defence mechanisms employed by the ego, and the way in which her ego and super-ego structures were organised. Data from the psychiatric history and from the therapy notes will be used to support the main arguments.

#### 7.5.2 The ego structure and its defences

A variety of adverse factors must be included in the discussion

of Adele's problems. The presence of a manic-depressive genetic loading in the paternal family, the dysfunctional family situation, and an apparently defective early mother-child relation culminating in that extremely traumatic early separation may all have played an important role in predisposing Adele to her adult problems. Such factors are not underestimated in the present discussion, but whatever their etiological roles, Adele still developed with an intrapsychic organization, and it is elements of this internal fabric which will be discussed here.

The central theme in Adele's life is her precarious identity. She herself expressed the experience of not having a core, of not being centered. Our argument will proceed from this basic lament which expressed itself in a variety of situations from her early childhood. More specifically it will be argued, in Kleinian terms, that Adele's depressive position was under the threat of collapse, that she had not managed to introject a secure, whole internal object and that, as a consequence, the ego still resorted to schizoid mechanisms of defence in the face of this failure.

At age 3½, Adele was so insecure and demanding that her mother could not manage her. Her early separation anxiety was so strong that she had to come to therapy accompanied by her mother or an elder sibling who usually stayed in the therapy room. In the playroom she would confine herself to imitating what the sibling did, ignored the therapist for at least 10 sessions and asked a host of questions which had to be answered. In other words, she was extremely controlling of others, was inhibited in her play activity and found it difficult to trust strangers. As she gradually became accustomed to the play therapy

situation she now exhibited great difficulties separating from the new situation. At the end of a session she would become extremely anxious, throw tantrums or would twist her hair repetitively and pull in her cheeks. She eventually resorted to taking a transitional object with her (black crayons) so as to bridge the sessions.

Such strong separation anxiety can be interpreted as Adele's failure to trust objects in her world and more specifically as a failure to establish a good internal object. She was still extremely dependent on the real object for her own internal 'goodness' or security, and as soon as frustrations crept in - unavoidable absences, the sheer inability of the object to fulfill her own insatiable greed - Adele's aggressivity was unleashed in the form of unmanageable tantrums.

It is suggested that this early separation anxiety was underlied by an object relation which was radically split. On the one hand, owing to projective identification, the good resided inside the object. It had to be greedily possessed and coerced so as to provide a sense of integration and security. Absence of the 'good' real object, however, led to the unleasment of very aggressive urges as a result of which the world became a 'bad' place. The absence of the good object was felt as disintegrative anxiety, as a fear of annihilation or of total loss. o god.

As a result the world was neither a safe place, nor was it trustworthy. Adele did not have enough internal security to trust that the absent object would return. Because of the existence of such early splits in the object and in the ego Adele could not successfully introject. Her ego at that time was using schizoid defences which prevented the

successful introjection of whole objects, the task par excellence of the depressive position. It is also evident that her repetitive, obsessional type of behaviour, was a means of controlling those early, powerfully operative anxieties.

At this juncture, it is fit to reflect on the importance of her early and perhaps fateful separation from her family. Her reaction to it was severe: she refused to eat for three days, she clung desperately to her baby sibling and developed her magical, ritualistic behaviour. Whatever difficulties Adele did have prior to the separation there is ground to suppose that this early trauma had the effect of hampering a successful negotiation of her depressive position. There is a thematic continuity between her early fears of separation and her adult lament: "I have no core, I don't know who I am".

Schizoid object-relations are pre-ambivalent in the sense that both love and hate are kept separate since the object and the ego are split. Alongside her desperate demands for the control of the external object Adele's early play therapy reveals the prevalence of extremely destructive and disturbing phantasies. On the whole Adele's play was limited, and her rare moments of spontaneity centered around plasticine and clay. The therapist reports several instances of "attacking the plasticine very aggressively, stamping on the clay, throwing it up in the air" and repeating that "she could beat it softer" than the therapist. Once, after having coerced the therapist into drawing her house, and dictating to her what colour to use, she expressed the following phantasy: "A house can burn ... my house will burn" and became extremely anxious. A house in Kleinian theory (Klein, 1932) is the representative par excellence of that most important

early phantasy structure of the mother's body. For Adele, mother's body was not a safe place to be in: it was dangerous and destructive in its split off, persecutory aspect. Only once did Adele play with dolls and enacted this revealing scenario: "Baby is crying and mother comes and hits it vigorously" reports the therapist.

This phantasy play exhibits all the elements of an extremely sadistic maternal imago. It also, in Kleinian terms, shows the internalisation of a very persecutory introject who does not spare the 'bad' little girl. In Kleinian theory the internal persecutor is the result of an introjection of a part-object projectively identified with the child's own destructive impulses.

The material from her early play therapy suggests that owing to strongly operative schizoid processes the primary object was split into a 'good' and a 'bad' part-object. This construction tallies with Adele's own ambivalence towards her mother, with her separation anxiety, and points to a failure in introjecting a whole internal object. Data from her adult therapy with the author, and from her later clinical history, will be adduced in an attempt to show that those early schizoid processes were still operative.

Adele's relation to her mother was still fraught with indistinction, a lack of separateness, as in her early childhood. On the one hand she wanted her mother to exist for her, and to answer to her every whim and fancy. Whenever she was stressed she would go back to mother but whatever mother gave her was never good enough. The smallest cues, such as inattention, or a response that was not exuberant enough, would provoke feelings of rejection and the long standing belief that mother never really wanted her. On the other hand, Adele wanted to separate

from her, and her yearning to establish herself independently was equally strong. She felt trapped and controlled by her mother.

The fundamentally split maternal object which permeated her psychological reality is perhaps best illustrated by Adele's own account of her manic breakdown. She spoke very little about her manic episode as it evoked considerable anxiety in her. In one particular session, however, she ventured into this encapsulated part of her biography. The sequence of her discourse here is particularly important. She started by recounting a particular behaviour during her most regressed state. She decided to drink only milk and was so pure that even her excrements did not smell. She then spoke about the food and clothes her mother would bring her whilst in hospital, how important those precious gifts were, and how they evoked in her very early feelings of warmth experienced as a little girl with mother. Her discourse abruptly changed in tone and Adele went on to speak about her terrifying dream at the time of her breakdown. The central image was terrifying: a foetus trapped inside a bottle. Her discourse grew in intensity and she started to express her strong mistrust about her mother. Her mother was a person who 'fed on her pathology', who sadistically enjoyed "looking at her 'madness', who controlled her and would not let go of her. She rounded off this particular session with a deeply nostalgic wail: "I know I've never got what I wanted from my mother. I often wish she was dead: I would feel freer".

This affectively draining session revealed the same radically split maternal imago present in her early childhood. On the one hand, a bountiful, perfect breast-mother full of magically pure and untarnished milk, and on the other, a sadistic, persecutory mother in which she felt trapped as a foetus.

Despite the fact that Adele was not overtly psychotic, when in therapy she at times manifested marked paranoid ideations. Thus when her mother left on an overseas trip she expressed her new found freedom but in the same session expressed the fear that at a distance her mother could control her, and sent poisonous substances behind the stamp of her letters. When her mother came back from overseas she again expressed her deep fears that her mother had always fed parasitically on her and that she exerted concrete control over her brain. Those ideations pointed to her schizoid mode of being and to the presence of highly persecutory part-objects in her psychical world. On the other hand, the maternal object was still an idealised object as a result of projective identification. Those splits were still operative both at the level of the object and of the ego.

Adele's emotional relationships with men were fraught with similar difficulties. Without a relationship she felt very insecure and anxious. When in a relationship it was very difficult for her to maintain her ego boundaries. Firstly, she adapted herself completely to their reality and would find it extremely difficult to assert herself. Her style was to attempt to fit in with the reality of her partners and she would do her utmost to accommodate them. However, sooner or later she would start feeling that her space was invaded and that she did not exert control over her own identity. This mode of relationship can be understood as resulting from the projective identification of good parts of herself with others. And since part of herself was in others, they exerted control over her - they invaded her space. As a result of the narcissistic character of her relationships others came to exert a tyrannical influence over her life, and her relationships were doomed to failure.

The same mode of relating was observed in the transference relationship with her therapist. Adele would often come to a session in a scattered, fragmented state. Her speech was incoherent and disordered. Yet in the course of the session a reorganisation visibly took place and a certain amount of integration would ensue. It was as if Adele needed an other for her own feeling of identity. In the absence of the other, fragmentation and internal confusion would result.

The central point made here is that Adele had developed an ego-structure whose boundaries were tenuous, whose orientation to reality was at times very precarious, and which still resorted to schizoid defence mechanisms in which projective processes, idealisation and splitting were still prominent. Consequently, following the distinction established in the theoretical section (Section 6.4) Adele exhibited an ego structure which was more regressed, and more disharmonious than the one which usually obtains in obsessional neurosis as described by the classical formula (Section 6.4). It was hypothesised that such a regression is linked to Adele's failure in negotiating the central task of the depressive position, that is, the successful introjection of a whole, undamaged object. As a consequence Adele's extensive obsessional symptomatology had a different valency to that which obtains in obsessional neurosis. Her mechanisms of control were in fact a desperate attempt, on the part of her fragile ego, to ward off more primitive anxieties of disintegration. This last point will be explicated in the next section.

### 7.5.3 The ego and its obsessional defence

Adele's compulsive controls were extensive and covered practically

every aspect of her life, in which there was little room for spontaneity. She spoke freely about her 'controls' and knew the place they occupied in her psychical life. Although she realised their crippling effect on her functioning, and used to refer to her super-ego in a derogatory way, she equated losing her controls to becoming manic or to losing her identity. It was clear in her mind that her prior therapy, aimed at a loosening of her controlling mechanisms and expression of affect, had led to ideas of possession: she started thinking that her therapist thought her own thoughts, and that everything he did was a means of controlling her. Furthermore, she often expressed the fear that if she dropped her controls she would start 'spinning' and would become manic again. Expression of emotions such as anger was for her tantamount to a dissolution of the world and of her self. She was scared of becoming ruthlessly insensitive to others, of thinking that she had omniscient and omnipotent powers. She established a direct link between her prior therapy and her manic episode. In other words, Adele's obsessional controls appeared to act as a defence against deep fears of disintegration linked to her own omnipotence and the omnipotence of others on her. It is important to stress at this juncture the necessity for a careful evaluation of obsessional symptomatology. It is evident that if therapy had been geared at working through her obsessional defence, it would have incurred the risk of bringing to the surface the more psychotic processes which underlay this defence.

If Adele's obsessional defence was useful to her ego it was on the other hand extremely maladaptive. The last section will focus on the nature of Adele's super-ego.

#### 7.5.4 The archaic features of the super-ego

Adele's reaction formations were harsh and her perfectionism boundless. She was extremely sensitive to being in the wrong and could feel devastated by the slightest criticism. Despite the fact that she was the best student in her class and even obtained the class medal, Adele thought very little of her performance. This extreme perfectionism manifested itself in a distorted approach to reality: if given an assignment she would not perceive it as a demand or a mere requirement in her course of studies. Rather it was felt as an honour conferred upon her, as a gift, and her problem was thus how to pay back this gift. She would set about, in the most compulsive fashion, reading everything around the topic and was forever uncertain about her ability and the 'good enough' nature of what she gave back. Klein's description of the mechanism of compulsive accumulation and giving (Section 5.2.2) articulates Adele's dilemma perfectly well. She did not have enough in her own fragile ego to give back what had been given to her, and had profound doubts about the 'good enough' nature of whatever she gave back. Fundamentally Adele was not receptive to injections from reality which were rewarding. This maladaptive perfectionism points to the presence of extremely severe introjects which still retained all the aggressive cathexes of her own destructive urges. It has been pointed out that since the age of 3½ Adele's psychical life was permeated by sadistic and omnipotent imagos. It appears that her perfectionism was an attempt to ward off the anxiety deriving from such harsh introjects.

Similarly her good introjects were idealised objects whose standards could never be matched. Whatever Adele did to meet the exigencies

of her idealised objects was never good enough. Adele was involved in an essentially reparative endeavour, as a trainee helping professional, but fundamentally she had no trust in her ability to make reparation. She was convinced that whatever she did she was not really helping the children she was working with. Weissman (1954) has pointed out that super-ego precursors lack permanence (Section 3.5). Adele was aware that her choice of a career, with which she was in constant conflict, was in fact not her choice but rather that of her mother within her.

#### Conclusion.

Adele's obsessional configuration, although more extensive than Alain's, did not warrant the diagnosis of obsessional neurosis from a descriptive psychiatric viewpoint (I C D 9, 1978). The evolution of her obsessional constellation from a young age up to adulthood was traced, and it was pointed out that Adele's case casts doubt as regards the legitimacy of making any prediction on the basis of early childhood symptoms.

Emphasis was placed on the ego-structure in Adele's case in an attempt to demonstrate that it was disharmonious and split, that its orientation to reality was precarious, and that it still resorted to schizoid defence mechanisms in order to deal with a type of anxiety which was psychotic in nature. Adele's obsessional defence developed within the context of an ego dissimilar to that which usually obtains in obsessional neurosis. Hence the obsessional defence was not only a means of warding off anal-sadistic impulses as in Alain's case, but especially a means of combatting a more primitive, disintegrative

anxiety. In other words, Adele's obsessional symptomatology had a different psychodynamic valency. The importance of such a psychodynamic assessment is that it enables the therapist to avoid the common assumption that working through the patient's controls is necessarily beneficial.

CHAPTER 8SUMMARY AND CONCLUSIONS

There is no need to reiterate the theoretical conclusions reached in Part I. The theoretical investigation into the classical and Kleinian viewpoints on obsessional neurosis stands on its own. The thesis has focused predominantly on one latent controversy in the psychoanalytic literature on obsessional neurosis and has attempted to make it manifest. M. Klein's notion of obsessional mechanisms, and their relation to obsessional neurosis, was systematically explored. The contradictions that emerged between the classical and Kleinian viewpoints were stated and evaluated (Chapter 6).

Alongside the primary theoretical aim of the thesis it was assumed that, owing to the spectrum of obsessional constellations, a thorough acquaintance with psychodynamic theory can assist the clinician both for diagnostic purposes and for a more judicious selection for psycho-therapeutic intervention with obsessional patients. Case I and II were presented so as to illustrate the relevance of both theoretical viewpoints on obsessional neurosis.

It is now suggested that Alain and Adele constitute ideal cases and may be construed as lying at the two poles of the obsessional spectrum. Alain's neurosis was mild in relation to more severe cases. The psychodynamic elucidation of the case, however, showed the usefulness of the classical etiological formula in throwing light on the internal fabric of such an obsessional constellation. Furthermore, by manipulating the various elements of the classical formula it was possible to reach an explanation as to why his neurosis was mild. It is

argued that it is within the ambit of the classical formula to explain satisfactorily a wide variety of obsessional constellations whose main dynamic elements do not significantly depart from those depicted by the classical formula. Such constellations feature varying degrees of severity and hence different prognoses which can be articulated in terms of the classical formula.

On the other hand, Adele's obsessional constellation was embedded within a psychodynamic fabric whose elements diverged significantly from those stated by the classical formula. Her clinical history featured a psychotic breakdown and she could not be diagnosed as an obsessional neurotic even on psychiatric grounds. The psychiatric literature, although lacking in precision, points in the direction of an interface between obsessional constellations and severe, psychotic depression (Nemiah, 1975; Rosenberg, 1968). Both the psychiatric literature (Kringlen, 1965; Rosenberg, 1968) and the psychoanalytic literature (Grinberg, 1966; Bychowski, 1966; Joseph, 1966; A. Freud, 1966; Nagera, 1976) point towards an interface between obsessional constellations and borderline or schizoid pathology. Similarly, the link, although tenuous, between obsessional symptomatology and schizophrenia (Stengel, 1945; Rosen, 1954) has been studied. It is thus suggested that there are obsessional cases in which no overt psychotic symptomatology is apparent on history-taking and yet can become psychotic when the obsessional constellation is analysed. In such cases the psychodynamic valency of the obsessional configuration is different to that which obtains in more typical cases like Alain.

Nagera (1976) adopts a strong stance vis-a-vis the notion of

obsessional neurosis as a 'facade' or a defence organization against psychotic disorders. He argues that such a notion is borne out of a conceptual confusion, based on faulty descriptive diagnosis rather than proper psychodynamic assessment. In his opinion the diagnosis of obsessional neurosis should be reserved if the elements of the internal fabric of a particular obsessional patient are in conformity with the classical etiological formula: "In 'ideal' conditions we will thus have a typical and clean obsessional neurosis: one that I do not believe will ever evolve into a psychosis and one that is not a defence against a more severe level of disturbance" (Nagera, 1976 : 131). In Nagera's logic those obsessional configurations which do deteriorate into psychotic disturbances are not properly speaking obsessional neuroses since their internal fabric shows elements that are different from those articulated by the classical formula.

Nagera's viewpoint is neat and appealing because it introduces a clear-cut distinction. However, it is categorical and does not allow for an empirical reality which is possibly more nuanced and not as clear-cut. Nagera's emphasis on the necessity for more psychodynamically informed diagnostic assessment is fully accepted but he does not specify the type of psychodynamic elements which, when present, would militate against the diagnosis of obsessional neurosis. It is therefore more appropriate to assess obsessional configurations on the basis of the degree of departure from the classical formula which they exhibit. The spectrum could then be divided into those cases which are typically obsessional neurotics, those which approximate the typical 'clean' case but show elements different from those articulated by the classical formula, and those which are clearly not obsessional neurotics. The exact demarcation line between

neurotic and non-neurotic is to a certain extent irrelevant since what really matters is the assessment of the psychodynamic valency of a particular obsessional configuration. On the basis of such an assessment the clinician can make more accurate predictions and better selection for psychotherapeutic intervention.

It is tentatively suggested, on the basis of the present work, that four factors must be taken into account in assessing the degree of divergence from the elements of the classical formula which any particular obsessional configuration may exhibit. The tentative nature of such a proposal is emphasised since it would have to be tested on a broader range of obsessional patients than the two cases presented in this work. The four factors are: the age of onset, the dominance of the anal-sadistic fixation, the structural aspects of the ego and the ego defence mechanisms, and the quality of the super-ego. They will be briefly reviewed.

### 8.1 The age of onset

It has been pointed out in this thesis that the age of onset of obsessional neurosis is a theoretically relevant issue (Section 6.2). Typical obsessional neuroses emerge either in adolescence or in early adulthood. Existing rigorous studies show that the earliest age of onset (Section 2.3.1) is usually in the latency phase. Furthermore, it has been pointed out that obsessional neuroses can be preceded by an infantile neurosis, as a result of Oedipal conflicts, which may assume different forms. Freud (1909) describes a post-Oedipal model of the later neurosis (Section 3.9). In the case of Alain an infantile neurosis featuring prominent anxieties, but with no clear

symptomatology as yet, preceded his adolescent obsessional neurosis. Nagera (1976) points out that typical obsessional neuroses are often preceded by phobias, during the latency phase, which vanish as soon as the obsessional neurosis develops.

On the other hand, it was argued, in accordance with the Hampstead Clinic opinion (A. Freud, 1965; Sandler and Joffe, 1965) that prominent pre-Oedipal obsessional configurations do not necessarily herald a later obsessional neurosis as M. Klein asserts (Section 5.4). but that they may in fact constitute defensive organizations against more fundamental pathology. The case of Adele was used to corroborate this argument.

It is suggested that particular attention be paid to post-Oedipal age of onset and to the infantile neurosis indicative of Oedipal conflicts. If pre-Oedipal obsessional configurations are present in a pre-Oedipal infantile neurosis this would constitute a significant departure from the classical formula to which the clinician should be alerted.

## 8.2 The dominance of the anal-sadistic fixation

In typical obsessional neuroses there is clear evidence of the 'regressive debasement' of the genital organization to the anal-sadistic fixation point of the drive. Severe conflicts over ambivalence between love and aggression and sexual ambivalence, in addition to the overarching presence of an anal symbolic, enable the clinician to establish the dominance of the anal-sadistic fixation. Furthermore, the severity of the drive regression can be gauged on the basis

of the degree of genital trends which have survived the regression.

The notion of dominance, however, does not exclude the presence of other fixations such as an oral or Oedipal fixation, but refers rather to the fact that the neurosis is organised dominantly around the anal-sadistic fixation of the drive. Such an organization is manifest at the level of the mode of object relations, and also at the level of the ego-organization, the defences it employs, and at the level of the super-ego. In Adele's case, in contrast to Alain, the anal-sadistic fixation did not constitute the nodal point around which her internal fabric was organized. Instead there was evidence of earlier disorders, orally anchored, and in which the defences of introjection and projection dominated.

The assessment of the dominant fixation points thus allows the clinician to assess the typical or atypical nature of the obsessional configuration.

### 8.3 The ego structure and the ego-defence mechanisms

This question has been extensively dealt with (Sections 3.6.1 and 6.4) in the present thesis. Only the most salient points which are relevant for assessment will be reiterated here. It seems particularly important with obsessional patients to assess the quality of their ego. Firstly, how intact is the ego's orientation to reality, and secondly, what type of defences is the ego resorting to?

In typical obsessional neuroses the ego maintains an adequate relationship to reality, the object cathexes are retained and there is no sign of a narcissistic retreat which characterises psychotic

types of disorders. This relatively high quality ego makes use of specific defence mechanisms, which explain the very form of obsessional symptoms, in an effort to ward off specific id urges. On the whole the ego is well differentiated from the id (Sections 3.6.1 and 3.7). The presence of more primitive defence mechanisms such as omnipotent denial of psychical reality, introjection, projective identification and radical splitting within the context of an ego-structure whose relation to reality is tenuous can alert the clinician as to the atypical nature of the patient's obsessional constellation. In such cases there are grounds to assume the presence of other more fundamental disorders in terms of which the obsessional constellation acquires a different valency. It has been argued that M. Klein's obsessional mechanisms characterise such clinical pictures rather than the more typical obsessional neuroses (Section 6.4).

#### 8.4 The quality of the super-ego.

Typical obsessional neurosis exaggerates the normal process of super-ego formation. This entails that on the one hand some of the super-ego introjects are very punitive towards the ego whilst others are more successfully established and facilitate ego development. The degree of super-ego regression can thus be established by weighing up the presence of successful identifications and their degree of permanence, in relation to the more primitive introjects which have retained the cathexes of the id (Section 3.5). Klein, on the other hand, has described the formation of an early super-ego made up of idealised and persecutory introjects (Section 5.6). In the two cases presented in this work there was a marked difference between Alain's and Adele's super-ego, the latter showing more primitive persecutory

and idealised introjects which partly explained her strong difficulties in coping with life.

It is suggested that, in dealing with obsessional patients it is important to attempt an evaluation of the degree of super-ego regression and the degree of primitiveness which obtains. Such an assessment can help to situate the particular patient in relation to the more typical super-ego formations which obtain in obsessional neurosis.

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