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FEW CLINICAL conditions serve as well for a study of aggression in its many expressions as do the obsessional neuroses. Aggression permeates the experience of the obsessional, playing a major role in the etiology of the condition and figuring prominently in the obsessional patient's symptomatic living.

There is general agreement that hostility, rejection, and power struggles mark the obsessional's early life experience. But such experiences are common in the history of many other neurotic patients. What seems specifically true in the case of the obsessional, as Sullivan[11] pointed out, is the hypocrisy typical of his family experience. In such a family, the parents camouflage hostile behavior toward the child with a facade of love and concern. They rationalize their own needs as being objectively right, and self-assertion by the child as wrong. This private, arbitrary system of morality is mediated through interpersonal operations creating anxiety, shame, and guilt. I have observed[2,3,4] that the discrepancy between the hostility implicit in the parents' destructive behavior and their explicit avowals of concern creates a dichotomy in the experience of the child. This dichotomy forms the nucleus around which a characteristic cognitive disorder develops which, I feel, is the central fault of obsessional living.

The dilemma created for the child in such a setting is that the explicit and the literal come to represent love, approval, and ultimately self-esteem, while the implicit and the inferred come to mean hostility, rejection and consequently self-contempt. He solves this dilemma by

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abdicating from selected areas of cognition, ignoring the input and inferred in order to maintain innocence about himself and the nature of his relation with others. This is especially marked in areas of hostility. Inference-making defects are created and maintained toward this end by the mechanism of implosion of affects," in which primitive and unstructured affects like anxiety and rage are forced inwards to disintegrate processes necessary for the organization and comprehension of experience. Implosion binds emotion within the psychic apparatus before its organization into expressive forms, creating apparent detachment in precisely those situations that would appropriately evoke anger.

The typical dependency problems of the obsessional also contribute to the dynamics of his aggression. The obsessional's family creates a paradoxical type of dependency. The child is simultaneously infantilized in regard to interpersonal skills and instrumental competence within the home, while considerable demands are made for him to achieve outside the home in school, work, or sports. Consequently, he seeks to verify his significance by performances of ever increasing perfection in the impersonal world outside the home, which then entitle him to the attention and applause he has no other means of winning. His insignificance to family life and the low premium put on his own needs and development as a person foster dependency, feelings of insignificance and incompetence in intimate situations, even in the face of his successes in the larger world.

The preoccupation with achievement, performance, and perfectionism resulting from this split type of dependency leads to the aggresive competitiveness so typical of many areas of the obsessional's life. Within the family this often manifests itself in severe sibling rivalry, and in the frequent hostile competitiveness that exists between the child and the parent of the same sex. In later life this same structure is reduplicated. Passively dependent and covertly hostile in his intimate life, the obsessional is openly aggressive and competitive in relatively impersonal areas such as business, intellectual pursuits, or in recreational activities such as sports or card-playing.

Having been unable to directly oppose and contest the infantilization to which he was subjected, he learns to utilize the dependent position as a weapon. It is as if he says, "You made me incompetent and enslaved me. Now you must serve me and be my slave." In place of "I won't," he substitutes "I can't." The underlying "won'tfulness" is implicit in the covert dictation that accompanies the assignments he

imposes on others, but he sees no inconsistency between his inability to do a job and his expertise in directing others to do it. He exercises his superior power in a given situation by interminably dragging his heels when he cannot refuse what is required of him. He manipulatively uses self-derogation to justify and enforce his willful oppositionalism.

The diminution of anger in his external life is based in part on implosion, and in part on the denial and suppression of anger, which the patient wants to avoid because of its implications of aggression and hostility. Depression, rumination, or withdrawal replaces anger in the patient's repertoire of responses. Competitiveness and power operations become means of discharging the tension of anger. Despite the absence of openly expressed anger, hostility is a frequent stance for the patient in his interpersonal behavior, often covertly but even blatantly enacted towards others in transactions that lend themselves to socially acceptable rationalization. Because of his difficulties in drawing inferences about interpersonal events, he is able to maintain denial of his own hostile intentions, even in the face of conscious fantasies and ruminations about gross violence, and even when his impact on others is clearly destructive. No evidence of his hostile effect on others shakes his belief in his own good intentions. When confronted by others about his hostility, he is often bewildered and unable to understand how he can be accused of hostility when he has expressed no anger. This confusion between anger and hostility reflects his cognitive style of literalizing experience and avoiding the implications of interpersonal transactions.

In some obsessional patients hostility takes the form of defiance. A system of hostile rebelliousness and oppositionalism is erected to deal with any conditions set, or limits placed on him, for love and approval. He is a rebel with a cause, and his cause is the unconditional love that was denied him as a child. He rejects any notion that adult love and approval are conditional on performance and behavior. He interprets the needs of others, in an interpersonal situation, as the coercive demands he once experienced. Caught, as were his parents, in the false morality of a cognitive system which defines his needs as right and the contrasting needs of others as wrong, he cannot comprehend the legitimacy of their claims on him no matter how appropriate they may be.

Another important expression of hostility in the obsessional is provocative behavior. Unlike the hysteric who provokes the environment

in order to seduce, the obsessional provokes others in order to externalize his hostility. By utilizing behavior subtly intended to provoke the environment to attack, the obsessional patient can engage in a hostile integration, free of awareness and of responsibility for the engagement. This type of behavior occurs most frequently when the patient is competitive with the other person. The obsessional style of provocation is devious and elliptical. It is usually disguised in a seemingly logical and non-aggressive cloak, often in the form of apparently innocent questions, which nevertheless are carefully pointed toward the opponent's vulnerabilities. Should the opponent not be wary, he soon falls into the trap and responds with rage and counterattack. The provocateur, however, acts injured and innocent, if he joins the fray, he does so only "to defend himself."

Probably the most common expression of hostility and aggression in the obsessional is his inhibition. Inhibition reflects his perception of the environment as hostile, and counters that hostility by his refusal to expose himself to it. Patterns of non-commitment, withholding, withdrawal, thwarting operations, and passivity are all expressions of this inhibitory mechanism, serving the purposes of both defense and offense against the hostile environment. The obsessional anticipates rejection and hostility especially in intimate situations. "To know me is to hate me," said one such patient referring to his underlying self-contempt and his perception of himself as irrevocably bad. His past experience has made him wary of tenderness and affection, which were the guises for the exploitation and rejection that he experienced in his family. Though the world he experienced was an infuriatingly hostile and exploitative one, he was restrained from direct expression of anger at this state of affairs by the anxiety, shame, and guilt with which his parents controlled him. His difficulty expressing anger directly and his dependency and ineptness in interpersonal situations suggest passive and covert rather than active and open solutions to the conflict.

In intimate situations he therefore develops a style of aggression, the major aim of which is to maintain interpersonal distance, by inhibiting his own expressiveness and by restricting his partner's responses. By withholding himself, by withdrawing interest and reaction, and by refusing to interact, he may successfully thwart the needs of his partner. This becomes the major punitive technique for the myriad, imagined slights and hostility that the obsessional reads into the behavior of those close to him. At the same time withdrawal limits

interactions that might expose him to shame for the hostile, aggressive, dependent, or narcissistic impulses he hides. Obstructionism, negativism, and techniques for distorting time, as, for example, compulsive tardiness, are other facets of the ungiving, withholding, and frustrating behavior utilized to aggressively thwart and control his interpersonal environment.

These techniques are especially effective in marital situations when the partner is an expressive or hysterical personality, and needs for contact and open interchange are therefore marked or even exaggerated. In the obsessional-hysteric marriage, the hysteric partner is frequently frantic about the covert punishment, anger, and control typical of the obsessional's interaction, while the obsessional is perplexed and bewildered because of his denial of hostility on the one hand, and his unfailing conviction that his intentions are good, on the other. In marital situations between two obsessional partners, Forrest[7] has observed that the mutual isolation and deprivation created by these withholding techniques may lead to mutual or alternating depression.

Withdrawal is a special and extreme instance of the inhibitory technique. As a hostile operation, withdrawal is most effective in an interpersonal conflict where anger or criticism exists, delivering the final blow by disengagement. Rationalized and justified as a legitimate response to the partner's aggression, withdrawal effectively retaliates by depriving the partner of response while at the same time passively and implicitly accusing her of aggression. Withdrawal may take several forms. In impotence, the dynamics of which I have discussed elsewhere,[5] this mechanism may be seen as an aggressive maneuver in the sexual sphere of intimacy. Depression, sulking, contemptuous, and ruminative forms of withdrawal may be identified, frequently as responses to situations which provoke anger.

The aggressive intrusiveness of many obsessional patients has several dynamic roots. The choice of this symptom is related to identification with an intrusive parent, as well as to the patient's competitiveness and narcissism. His self-esteem has been so badly damaged that constant reparation is sought. He incessantly clamors for approval and applause, and demands that he be considered the center of the universe. Others are seen as appendages or as audiences, rather than as human beings with their own needs and sensitivities. He dictatorially obliterates the other person by refocusing every event on himself, leaving no room for the other's individuality. Should others

try to assert their own needs, especially for intimacy, he distorts these attempts into intrusions and invasions of his life space. Usually his own aggressive intrusiveness is disarmingly rationalized as wishes to share and participate in events.

Paradoxically, while the obsessional uses withholding and thwarting techniques in his operations with others, he feels thwarted and stymied in his efforts to secure the narcissistic and dependent supplies he needs from them. With his guardedness and anticipation of hostility in intimate situations, he is quick to interpret the behavior of others as slights and disparagement. His underlying sense of shame is the foundation on which he erects an endless experience of being humiliated by others.

The anger and rage provoked by these misinterpretations are augmented by a narcissistic ploy common in the obsessional's intimate relationships. This ploy involves a conversion of the partner's giving (e.g. of love or sexual pleasure) into a possession of the patient's. His partner's love is now his due. Should it be even temporarily withheld, as, for example, when she is too tired or emotionally distraught to engage in sex, the obsessional patient feels as though something is being taken from him rather than that something is no longer being given. This cognitive shift, basically derived from his narcissistic self-absorption, serves to eliminate the need for feelings of gratitude or loyalty in response to his partner for her giving, while justifying his claims on her, and his anger that he is deprived when his demands are not met. The bind that this creates for the obsessional's partner is that, while ever increasing demands are being made on her, ever decreasing returns result. This situation sorely taxes even the most christian orientation to intimacy.

Depression is another important vehicle for the obsessional's aggression. Because of the implosive handling of affects, depression is present in all obsessional patients in overt or covert forms.[4] As Bonime[6] has shown, depression is a style of living with manipulative and hostile implications for the patient's interpersonal operations. A study[7] of the marital interaction of severely depressed patients confirms this impression.

Depression serves both as an extension of and a justification for the obsessional's hostile withholding operations. Depression adds a note of accusation and guilt provocation to the withholding operations ("Look what you've done to me"), and exploits vulnerability to disable the partner's response ("How can you kick me when I'm

down?"). As a justification for withholding ("How can I respond when I'm so depressed?"), depression communicates both a denial of the hostility implicit in the withholding operation and a rationalization for the patient's ungiving and unresponsive behavior.

On yet another level, depression serves both the patient's narcissism and his dependency. The obsessional is often engaged in competition for care and attention in his intimate relationships. Depression reinforces the priorities of the patient's demands while at the same time serving to restrict his partner's legitimate claims in the relationship.

Shame is an affect of considerable importance in the experience of the obsessional and plays a central role in his stylistic handling of aggression. To avoid the humiliation to which he was subjected when his aggressive or self-assertive impulses were apparent, he needs to maintain innocence of these interpersonal affects and of operations that would increase his self-contempt. The obsessional creates a secret life in which he may enact his hostility and aggression in fantasy, while denying their implications in reality. Although he expresses little anger and denies hostility and aggressive motives, his private experience is filled with episodes in which thoughts and fantasies of aggression occur. His frequent ruminations involve vindictive, retaliatory acts or grandiose, triumphant battles. The stimuli for such fantasies vary from the normal frustrations of daily life, such as those involved in driving a car in traffic, to more complex interpersonal situations that fail to meet his needs. In some patients, the secret life may be acted out either by discrete compulsive acts of open aggression or sadism, or in a fully organized jekyll-and-hyde situation in which the secret life of aggression is kept isolated from the patient's more conventional life.

Although guilt has an important relationship to obsessional aggression, its significance has been greatly overemphasized in classical theory,[1,8] which holds that guilt from an excessively severe superego is central to obsessional dynamics. I suggest that obsessional guilt is not based on the severity of conscience, but rather on a defect of conscience. Obsessional guilt is related to two important historical factors in the patient's experience. It is a response both to the blaming operations used by his parents to constrain him, and to the arbitrary morality they established by defining right and wrong in terms of their own needs, without regard for the needs of the child. In the

obsessional, narcissistic and dependent considerations create a form of guilt which is primarily oriented towards fear of retaliation and retribution. It is largely a fear of blame, of being held accountable and consequently suffering disapproval and rejection. The focus in this type of guilt is the maintenance of the spurious type of self-esteem he derives from external approval.

I feel that the development of the capacity to comprehend and to be concerned with the implications of one's impact on others would give rise to a truly humanistic conscience. Guilt arising from such a conscience would involve ethical considerations concerning one's behavior and one's impact on others. The obsessional, limited both in inference-making and in concern for the needs of others, shows little true guilt about his behavior. In fact, his own covert blaming operations make him adept at creating guilt in others for the hurts and disparagement he experiences in interpersonal transactions.

Anxiety is also significantly associated with the dynamics of obsessional aggression. In a well-functioning obsessional cognitive system, there is little free-floating or felt anxiety. Most of the obsessional's anxiety is bound either into its implosive use to maintain innocence, or into obsessional thoughts and actions. The obsessional patient, consequently, seems to manifest little anxiety on the surface. At the most, they report only what Solomon[10] has described as the background of turbulence experienced and even needed by the obsessional. This turbulence is symptomatic of the many poorly structured affects, like anxiety, which are used to maintain innocence by the mechanism of implosion.

The primary role of anxiety is the maintenance of the self-system. Since much of this, in the obsessional, is organized around aggression, anxiety occurs mostly when rage or angry feelings erupt into awareness. At those time, anxiety of an extremely intense nature may occur. Under these circumstances, anxiety may be so overwhelming that the patient fears impending personality disintegration or insanity. Anxiety is also prominent when major obsessional systems decompensate because of changes in the patient's life situation, for example, when a coronary occlusion restricts a compulsively driven, perfectionistic, and competitive business man. This type of anxiety lies beneath the frequency of agitated rather than retarded depressions when obsessional decompensation occurs.

The periodic rage reactions seen in obsessional patients deserve note. Rado,[9] who sees obsessional rage as derived from the temper

tantrums often observed in the patient's childhood, feels that the typical obsessional rage reaction differs from these temper tantrums primarily in being retroflexed and directed against the self rather than being expressed. While I agree that this is true of obsessional anger, I find that the episodes of explosive rage which are frequent in the obsessional are more complex phenomena. They are related both to the moods of impotent paralysis to which the patient is subject and his deeply repressed self-contempt and perceptions of being humiliated by the intimate environment. The episodes usually occur when the patient feels cornered and trapped after his covert and passively hostile techniques are confronted in intimate interchange. The response is the result of both anger and shame at being exposed. Its quality of intensity and anguish is primarily directed to the narcissistic wound, while its characteristic form as an attempt to hurt or degrade the other person is meant to force her withdrawal to end the intolerable pain of exposure and contempt.

In terms of the patient's own experience, these outbursts of rage are frequently seen as identifications with the parent whose destructive behavior was most problematic in the patient's childhood. They therefore serve to increase feelings of shame and to consolidate the obsessional defenses again. Following such an outburst, the obsessional often feels purged, contrite and once again in good control, especially if it has served its purpose of creating disengagement from the confrontation which precipitated it.

Despite the great variation in behavior patterns associated with obsessional aggression, they may be seen to share certain characteristics. The cognitive system of the obsessional seeks to maintain innocence of his hostility to others as well as of their hostility to him. To maintain this innocence the obsessional's aggression is enacted more or less covertly. It is more often aggression by omission than commission, but as real and as absorbing to the obsessional as the pyrotechnical displays of more flamboyant personalities. Much of the grimness of obsessional living revolves about the dynamics of aggression. It is therefore essential that these patients understand and resolve these problems in psychoanalytic treatment if they are to escape the isolation and loneliness they themselves perpetuate.

REFERENCES

1. Abraham, K., "Contribution to the Theory of the Anal Character," in *Selected Papers on Psychoanalysis* (New York: Basic Books, 1953) 370–392
2. Barnett, J., "On Cognitive Disorders in the Obsessional," *This Journal*, 2 (1966) 122–134.
3. ———, "Cognitive Repair in the Treatment of the Obsessional Neuroses," *Proceedings of the IV World Congress of Psychiatry*, Madrid 1966, Excerpta Medica International Congress Series No. 150, pp. 752–757
4. ———, "Cognition, Thought and Affect in the Organization of Experience," in Masserman, J. (ed.), *Science and Psychoanalysis*, Vol. XII (New York: Grune & Stratton, 1968) 237–247
5. ———, "Sexuality in the Obsessional Neuroses," delivered at the Midwinter Meeting of the American Academy of Psychoanalysis, December 1968, In press
6. Bonime, W., "The Psychodynamics of Neurotic Depression," in Arieti, S. (ed.), *American Handbook of Psychiatry*, Vol. III, (New York: Basic Books, 1966) 239–255
7. Forrest, T., "The Combined Use of Marital and Individual Therapy in Depression," *This Journal*, pp. 76–82, this issue.
8. Freud, S., "Character and Anal Eroticism," in *Collected Papers*, Vol. II, (London: Hogarth Press, 1950) 45–51
9. Rado, S., "Obsessive Behavior," in Arieti, S. (ed.), *American Handbook of Psychiatry*, Vol. I (New York: Basic Books, 1959) 324–344
10. Solomon, J. C., "The Fixed Idea as an Internalized Transitional Object," *Am. J. Psychother.* 16 (1962) 632–644.
11. Sullivan, H. S., *Clinical Studies in Psychiatry* (New York: W. W. Norton, 1956).

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