Type	Obsessive Compulsive
General	Organized around thinking and doing dominance of thinking (obsessional character); dominance of doing (compulsive character) used in a defensive mode the two classes of symptoms can be separated obsessions and compulsions are normally present in persons who are not obsessional or compulsive as character
Affect, Drive, Temperament	**Rectal hypersensitivity - Anal fixation** aggressive urges. OC attitude may originate in early dyadic struggles over toilet training scenario resulting in issues about cleanliness, stubbornness, concerns with punctuality, tendencies towards withholding but possibly also around eating, sexuality and general obedience. The experience of being controlled, judged, and required to perform on schedule creates angry feelings and aggressive fantasies, often about defecation, that the child eventually feels as a bad, sadistic, dirty, and shameful part of self. **Harsh all-or-nothing superego sphincter morality** **Affective conflict** **rage** (at being controlled) **vs. fear** (of being condemned or punished) **Affect is muted,** suppressed, unavailable or rationalized; words are used to conceal feelings not to express them **anger is the acceptable feeling** if it is based on righteous indignation shame
Defenses	Obsessives **isolation of affect** Compulsives **undoing** unconscious meaning of atonement and magical protection Deleterious compulsions such as overdrinking, overeating, taking drugs, gambling, shoplifting, sexualizing more characteristic of people at borderline level of organization For higher functioning people isolation is used as separation of affect from cognition i.e., rationalization, moralization, compartmentalization, intellectualization. **Displacement** **Reaction formation** - a defense against tolerating ambivalence Against wishes to be irresponsible, messy, profligate, and rebellious. Incessant rationality reaction formation against a superstitious magical kind of thinking.
Object relations/ interpersonal	**Caregivers set high standards and expect early conformity with them**. Problems occur when the parents are unreasonably exacting, prematurely demanding, or condemnatory not only of unacceptable behavior but also of accompanying feelings, thoughts and fantasies. **Centrality of the issues of control** in their family **guilt and shame-inducing** upbringings **Induction of guilt** - I expected more...from a.. like you! **Induction of shame** what would people think if you re..? **Idealization of self-control and deferral of gratification** **The opposite of the overcontrolling moralistic family milieu** lack of standards children do not model their parents but take their standards from cultural/social sources imposing on themselves tasks that are unbuffered by a humane sense of proportion. The family acts as a countermodel. the paradox of the harshest superego in those who were laxly parented.
Self	Both obsessive and compulsive people are so saturated with irrational guilt and shame that

	they cannot absorb any more of these feelings. Deep concern with control and moral rectitude **equate right behavior with keeping away aggressive, lustful, and needy parts of self** **fear they own hostile feelings** they regard not only behaviors but also feelings as reprehensible may nurture a kind of private vanity about the stringency of their demands on themselves. self esteem comes form meeting the demands of an internalized parent **Obsessives** - worry a lot esp. when they have to make a choice that might turn badly **doubting mania** the effort to keep all the options open postpone the decision until it will be clear what the perfect decision would be. **Compulsives** jump into action before considering alternatives instrumental thinking and expressive feeling are circumvented. When circumstances make it hard for the o/c individuals to feel good about themselves on the basis of what they are figuring out or accomplishing they become depressed. Avoid affect-laden wholes in favor of separably considered minutia they cannot see forest for the trees.
Transference/ Countertransf.	**Transference** good patient but difficult they experience the therapist as a demanding and judgmental parent **become consciously compliant but unconsciously oppositional**. there is something very object related about their unconscious devaluation/ dutiful cooperation plus undertone of irritability and criticism when the therapist comments on such feelings they are usually denied **Countertransference** the combination of excessive conscious submission and powerful unconscious defiance can be maddening annoyed impatience, wish to shake them to be open about ordinary feelings, to give them a verbal enema or insist that they shit or get off the pot sensation of the rectal sphincter tightening in identification with the constricted emotional world of the patient (concordant) or in a physiological effort to contain one s retaliatory wish to dump on such an exasperating person. feeling of boredom for the client s unremitting intellectualization less feelings of insignificance, boredom and obliteration that common during the treatment of narcissistic patients doubts about whether anything is being accomplished in therapy are typical for both the client and the therapist, esp. before the client is able to voice these feelings out.
Therapeutic implications	**First rule of practice ordinary kindness** they are used to being exasperating to others for reasons they do not fully comprehend, and they are grateful for nonretaliatory responses to their irritating qualities. **Refusal to advise them, hurry them, and criticize** them for the effects of their isolation, undoing, and reaction formation will foster more movement in therapy than more confronting measures. An exception to the rule of refusing to advise compulsions that are outright dangerous (self-destructive). Options either tolerate anxiety about what the patient is doing until the slow integration of the therapy work reduces the compulsion to act (preferable if the compulsion is not life threatening), or, at the outset, make the therapy contingent on client s stopping the compulsive behavior may contribute to the fantasy of the patient that therapy will operate magically without their having at some point to exert self-control. By accepting compulsively self-harming people into analytic treatment unconditionally the

	therapist may contribute to their fantasies that therapy will operate magically. **Emotional disengagement to be avoided**. Asking the patient s direction about how much the therapist should speak, may support patient s autonomy and sense of self support. **Power struggles may produce temporary affective movement but in the long run they only replicate early and detrimental object relations**. For obsessive persons **interpretations that address the cognitive level of understanding before affective responses have been disinhibited will be counterproductive**. The difference between intellectual and emotional insight is striking in these cases. One was to bring more affective dimension to the work is through imagery, symbolism, and artistic communication more poetic style of speech rich in analogy and metaphor. Help them express their anger and criticism about therapy and the therapist lay the ground of it. **Go beyond identification of affect to encouragement to enjoy it**. **It is useful to comment on their difficulty tolerating just being rather than doing**. If this patient ca be convinced that expressiveness is something other than pathetic self-indulgence.
Differential diagnosis	**Obsessive vs. Narcissistic** It is more harmful to treat a narcissistic as a compulsive than the other way around. Nevertheless, an old-fashioned, moralistic o/c will be distressed by being seen as needy rather than conflicted. **Obsessive vs. organic conditions** Perseverative thinking and repetitive actions of organic brain syndromes.