A Specific Developmental Deficit in Obsessive-Compulsive Disorder: The Example of the Wolf Man

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In this paper I suggest that the origins of the "contamination/cleaning" form of obsessive compulsive disorder (OCD) include a developmental history characterized by marked overprotectiveness allied with parental failure to respond to core aspects of the child's personal reality. The combined effect of these parental behaviors is likely to impede the establishment of a mature conception of the boundary between inner and outer worlds. The consequence of such a deficiency is the persistence of the magical form of thinking which is essential to the production of OCD. In addition, the individual is left with a disruption of personality development, the main features of which include timidity and falseness. The Wolf Man provides an example of both the characteristic development history in OCD and its consequences. Treatment based on this theoretical background may provide benefit not predicted by current psychoanalytic pessimism.

ALTHOUGH FREUD WROTE 14 PAPERS ON OCD he found, toward the end of his life, that "as a problem it has not yet been mastered" (Freud,

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1926, p. 113). There has been little advance since his time. Indeed, therapeutic disillusionment with the disorder has been such that very little psychoanalytic inquiry into its nature has occurred over the last few decades. A consensus has arisen that the traditional approach to treatment is not likely to be effective. A new approach must be found. Freud's observations provide a starting point for working toward a revised therapeutic method in OCD. Freud identified a central feature of the illness. He called it "the omnipotence of thoughts." It is fundamental to the generation of OCD symptomatology. I argue that this phenomenon is a consequence of the particular kind of early family environment experienced by those who later suffer OCD. The story of the Wolf Man illustrates this kind of developmental history, which, it is postulated, has the effect of impairing the formation of a mature conception of the distinction between the inner and outer zones of experience.

The Biological Case

Before embarking on the main argument it is necessary briefly to confront a prevailing viewpoint that mitigates against a psychodynamic understanding of OCD and that potentiates the already pessimistic attitude of therapists toward this illness. Those who see OCD from this position contend that it has, primarily, a neurophysiological basis. This view is based on two main bodies of data: genetic and brain imaging.

Pauls et al. (1995) reviewed the principal evidence for a genetic component in the aetiology of OCD. The findings of most family studies favored the idea. In some cases, there was also a family history of tics. In their own study, involving 100 cases, they found about 10 percent of relatives of those with OCD also suffered from OCD. This compares with a prevalence in the general population of about 2 percent (Robins et al., 1984). Although there are negative findings (e.g., Black et al., 1992; Bellodi et al., 1992) and adoptive studies have not yet been reported, it is reasonable to conclude that in many cases a genetic vulnerability is a factor in the genesis of OCD.

Brain imaging studies indicate that such a genetic vulnerability may be mediated via the hyperactivity of certain neuronal circuits. Although the evidence of coarse structural brain abnormalities in OCD is minimal (Kellner et al., 1991), functional studies show

hyperactivity in the orbitofrontal cortex (Baxter et al., 1988; Nordahl et al., 1989; Rauch et al., 1994), the left anterior cingulate gyrus (Rauch et al., 1994), and caudate regions (Baxter et al., 1992; Rauch et al., 1994) in those with OCD. This configuration of brain activation in OCD is not immutable. It is no longer evident on recovery (Swedo et al., 1992; Baxter et al., 1992).

These findings support the hypothesis that circuits involving the basal ganglia, the limbic system, and the orbitofrontal cortex may underpin OCD (Alexander, DeLong and Strick, 1986; Alexander, Crutcher, and DeLong, 1990). However, in my view, this activity is not sufficient for the production of OCD. This view depends upon the clinical observation that at least two characteristics of thought are necessary to the formation of OCD. The first of these involves repetition; the second characteristic, identified by Freud, is the curious and magical power those with OCD attribute to their thoughts. My argument rests on the assumption that the tendency to repetitive, cycling thoughts, analogous to a "mental tic," is an aspect of genetic vulnerability, while the "omnipotence of thoughts" is a consequence of development. It is the latter that is the disabling factor in OCD. Iterative thought is not, in itself, pathological. Many people have the experience, from time to time, of a thought or tune recurring in their minds in a way that is often irritating and intrusive. Their lives, however, are not taken over by the need ceaselessly to perform senseless rituals.

The foregoing assumption implies a multimodal treatment approach. Since the pattern of iterative thinking must be neurochemically mediated, a pharmacological approach to it is appropriate (Zohar and Inser, 1987; Goodman, McDougle, and Price, 1992). However, the efficacy of pharmacotherapy can be overstated. This is demonstrated in the outcome of a recent important multisite trial of a selective serotonin uptake inhibitor involving over 300 patients. About a third were placed on placebo while the others were given varying drug doses. All patients were carefully monitored over a 12-week period during which they were given eight extensive evaluations involving questionnaires, interviews about side effects, and also, less frequently, physical examination, ECG, and routine blood tests. Both groups steadily improved over the 12-week period. Thirty percent of placebo-treated patients were much improved or better. The figure for the drug-treated group was 38 percent. In essence, this trial could

be seen as showing that ordinary medical care produced a 30 percent treatment effect, while medication exerted an additional benefit of 8.9%. It should be noted that the durability of response to medication is likely to depend on continuing medication (Pato et al., 1988).

In summary, these data and ideas lead to the view that medication is unlikely to provide adequate therapeutic benefit for the typical case of OCD. The argument put forward here is that the personality structure that underpins the "omnipotence of thoughts" must, in many cases, be approached psychotherapeutically.

The Omnipotence of Thoughts

As previously remarked, the work of the psychotherapist is directed toward the "omnipotence of thoughts." Freud (1913) described a person in the grip of this form of thinking. He is:

> unable to believe that thoughts are free and will constantly be afraid of expressing evil wishes, as though their expression will lead inevitably to their fulfilment. This behavior, as well as the superstitions which he practices in ordinary life reveals his resemblance to the savages who believe they can alter their external world by mere thinking [p. 87].

The magical beliefs that are the basis of the "omnipotence of thoughts" are found in the rituals of most societies and also held by children, as Freud noted. A consideration of this form of childhood thought led Piaget to propose that magical thinking is a consequence of the child's not yet having formed the mature conception of an inner life that is distinct from the outer world. The development of this concept, which is to be distinguished from a percept, can be charted by studying the attainment of the concept of secrecy (Meares and Orlay, 1988) and by the observation of "false belief" (Perner, Leeham, and Wimmer, 1987; Gopnik and Astington, 1988). These studies suggest the concept of self-boundary is gained at about the age of 4, with fairly wide individual variations.

Freud had noted the deficiency of the conception of boundary in a tribal system dominated by magic. "Telepathy," he remarked, "is taken for granted" (1913, p. 81). He referred to Fraser's (1954) classic *The Golden Bough* in developing an understanding of magical belief.

Although he does not make it explicit, Fraser's explanation of magic resembles Piaget's. He considered that magic depended upon two main principles. He called them the Law of Similarity and the Law of Contagion (p. 11). The latter clearly depends on the belief in an incomplete boundary between self and world. An individual's feelings, thoughts, and wishes can, as it were, seep into the environment, so influencing it. Contagion goes in both directions, so that universal events or aspects of the environment can seep into people and have an effect upon them. Examples of contagious magic include the belief "that epilepsy can be cured by striking the patient on the face with the leaves of certain trees and then throwing them away. The disease is believed to have passed in to the leaves, and to have been thrown away with them" (Fraser, 1954, p. 539). Freud (1913, p. 80) quoted another of Fraser's examples involving rice farmers and their wives engaging in sexual intercourse in the rice fields at night in order to enhance the crop, as if their own fertility would infect the field itself. The magical sense of contagion was apparently experienced by the Wolf Man in a period when he was free of OCD. One day, as he was driving with his future wife in a car, she "suddenly felt ill, and a few minutes later I also felt unwell. This feeling did not last long, but neither of us could explain what caused it. Later I interpreted this as a presentiment of approaching trouble" (Gardiner, 1971, p. 76).

A society dominated by the system of contagious magic is an uneasy one. Various rituals are institutionalized in order to ward off contagion. They closely resemble that of the individual sufferer from OCD. Freud noted that the OCD patient lives in an atmosphere of dread, as if some disaster were about to occur. He remarked: "Whenever I have succeeded in penetrating the mystery, I have found that the expected disaster was death" (Freud, 1913, p. 82). He found that the obsessional was preoccupied with death. He wrote: "Their thoughts are increasingly occupied with other people's length of life and possibility of death; their superstitious propensities have had no other content to begin with and have perhaps no other source whatsoever" (1909, p. 236). At bottom, the death that is feared is their own.

The threat of death comes from two directions. The first is from the environment. The subject is constantly at risk from malignant universal forces represented in dirt, germs, feces, and putrefaction.

The fear of contamination is, in most studies, the single most common obsessional theme. Thomsen (1991), for example, found that the most frequent obsessive content in 61 Danish patients was thoughts about dirt and contamination, followed by concern about death, illness, and harm. Fears of contamination were the most common obsessions in India (Khanna and Channabasavanna, 1988) and Japanese (Honjo et al., 1989) and Egyptian studies (Okasha et al., 1994). In the latter study, religious obsessions were equally common, followed by somatic obsessions. Confirmation of these fears through bereavement or threats of health often precipitates the illness (Khanna, Rajendra, and Channabasavanna, 1988).

The second threat of death arises through the magical effect of feelings and wishes upon attachment figures. The individual fears that not only wishes but also unbidden thoughts may harm those close to him or her. Consequently, "an obsessional neurotic may be weighed down by a sense of guilt that would be appropriate in a mass murderer, while in fact, from his childhood onwards he has behaved to his fellow men as the most considerate and scrupulous member of society. Nevertheless, his sense of guilt has a justification; it is founded in the intense and frequent death wishes against his fellows which are unconsciously at work in him. It has a justification if what we take into account are unconscious thoughts and not intentional deeds" (Freud, 1913, p. 87).

A more fundamental fear arises from these wishes. Those who may be damaged by the obsessive thoughts are those upon whom the obsessional's sense of existence depends. The demise of the attachment figure will bring about a state in the subject analogous to the threat of death. Sylvia Anthony's (1971) studies showed that the child's concept of death was related to "separation from the mother or the person who gave the child most care" (p. 145).

The sense of threat to one's existence through the absence of the other is a feature of life before a fairly mature conception of self-boundedness is achieved. Attachment figures are conceived, at least so Spitz (1950) supposed, as necessary parts of the self-system, something like a rather special limb. Mahler's (1968) views were somewhat similar. Seen in this way, the separation anxiety of normal development is a manifestation of the child's failure to have yet attained the concept of an inner world that is distinct from the outer one (Meares, 1986). Since it is hypothesized that the formation of this concept is immature in those with OCD, it will be predicted that

these patients will be particularly vulnerable to separation fears. Clinical evidence supports the prediction. Threats to dependence needs may precipitate the illness. This was so for Mr. A. He had lived with his parents until rather late in his life. He was treated as a special child in comparison to his younger brother. In his thirties he married an extremely "good" woman, who cared for him inordinately. They continued to live with his parents. His illness began with the birth of their child. His obsessive thoughts were fears of killing it.

It will now be evident that the obsessive-compulsive is immersed in anxiety. First, there is the danger of contagion creeping in from the environment. Second, there is the separation anxiety induced not only by actual absence, but also through the harm inflicted by the omnipotence of thoughts, as Klein (1934, 1935) suggested. Reverberation between these two sources of anxiety may cause it to escalate, heightening the apprehensive expectation of some disaster, analogous to death. In such a situation, something must be done to prevent the imminent catastrophe. As the Rat Man put it: "I had *an uncanny feeling, as though something must happen if I thought such things, as though I must do all sorts of things to prevent it*" (Freud, 1909, p. 162).

Freud pointed out that the obsessive now constructs a magical counterworld in order to protect himself from the dangers that seem to besiege him. The individual's personal life now becomes like the social system of those societies in which magical thought is dominant. Against the pervasive fear of contagion is built an overrigid system of rituals and controls that involve, "separations, demarcations, purifications, and punishment of transgression" (Douglas, 1966, p. 4). The ritualistic behaviors of the OCD patient, since they are designed to reduce anxiety, become conditioned. Learning theory must not be neglected in the management of these symptoms. This is consistent with the multimodal approach mentioned previously. It is also consistent with the Freudian remark that: "One can hardly master a phobia if one waits till the patient lets the analysis influence him to give it up" (Freud, 1919, p. 165).

Boundary, the Environment, and Overprotection

The suggestion put forward here is that the magical behavior of the patient with OCD has its origin in the obsessive's failure adequately to conceive a personal and interior zone that is distinct from the outer

world. This deficiency was observed by Freud in his work with the Rat Man. Freud noted that his patient believed that the beginning of his illness came with the "morbid idea," as he put it, "*that my parents knew my thoughts: I explained this to myself by supposing that I had spoken them out loud, without having heard myself do it*" (Freud, 1909, p. 162). Freud italicized this remark, impressed by its significance. A few sessions after this the Rat Man admitted that the belief his parents knew his thoughts had persisted for the whole of his life (p. 178).

Similar experiences, with varying degrees of severity, are recounted by contemporary OCD sufferers. For example, a woman of 23 said that she was uncertain whether she had merely thought things or had spoken them aloud. As further evidence of her ill-defined conception of self-boundary, she remarked that, when people went away, they took a part of her with them, as if this were literally so. Another patient's awareness of the fragility of "the privacy of the self" seemed to be signalled by his need to perform an extraordinary series of routines that guarded against the possibility of being observed from the street while he undressed in his bedroom. This behavior heralded the onset of OCD. He resembled those in Janet's classic series whose sense of exposure was such that they had to be quite alone while undressing (Pitman 1984, p. 310).

What might be the origin of a deficiency in the formation of a conception of self as bounded? In order to attempt an answer, we must return to Piaget. Piaget (1929) considered that the period in a child's life in which magical thinking was prominent coincided with a phase he called egocentric. During this period, self and the world are not conceived as quite distinct. To some extent the child conceives the universe as part of himself or herself, and those people in it are also parts of self. The personal world is, to a large extent, exterior (Gruber and Voneche, 1977, pp. 132, 200–205). In order to move beyond this conceptual stage, children must discover that there are other realities than one's own. This comes about, at least to some extent, through the child's encounter with the world. This idea was expressed by both Piaget and Vygotsky.

Piaget, like Freud, had noted that magical thinking was part of the culture of so-called primitive, or hunter-gatherer, societies. Vygotsky (1962) criticized this generalization, pointing out that "we could not call agriculture and hunting negligible contacts with reality in the

case of primitive man; they are practically his whole existence" (p. 23).

Despite Vygotsky's criticism, Piaget was well aware of the necessary effect of social life on the child's emergence from the phase of magical belief. He wrote: "Without collaboration between his own thought and that of others, the child would not become conscious of the divergences which separate his ego from that of others, and he would take each of his perceptions or conceptions as absolute. He would therefore never attain to objectivity, for lack of having ever discovered his own subjectivity. Without social life, he would never succeed in understanding the reciprocity of viewpoints, and, consequently, the existence of perspectives, whether geometrical or logical. He would never cease to believe that the sun follows him on his walk" (Gruber and Voneche, 1977, p. 137).

Both Piaget and Vygotsky suggest that where the adult individual is able to grapple with the environment, to test it out, to find one's suppositions failing, magical thinking is not in evidence. On the other hand, where the world cannot disprove one's view of it, magical thinking may persist. These ideas suggest that the child needs, at times, to find that the environment is not as he or she has supposed, that others are not merely an extension of oneself, that they have their own wishes and feelings. In the interchange and "collaboration," as Piaget called it, with others, as with the physical world, the child will take small risks in the testing procedure. In this way, the child comes up against another reality, an "objectivity," which, through its difference, creates a sense of boundary between the "subjectivity" of self and a world outside.

These ideas suggest that, where the parents are overprotective, the child's conception of the boundary of self will be impaired. This notion leads to the prediction that OCD will be associated with such a family background. The prediction is supported not only by the author's clinical observations on a series of inpatients with OCD diagnosed according to DSM-IV criteria, but also by family studies of OCD, which unfortunately are relatively few and limited in methodology.

Overprotection in the developmental history of OCD sufferers has been demonstrated in three questionnaire studies (Ehiobuche, 1988; Hafner, 1988; Cavedo and Parker, 1994). This overprotection, allied to the patient's dependence, typically persists into later life, as in the

case of Mr. A. Ms. B provides a second example. She was a 46-year-old spinster who still slept in her parents' bedroom. Mrs. C, after her marriage breakup in her twenties, returned to her mother, in whose bedroom she slept. Miss E, aged 23, also slept in her mother's bedroom. This kind of story suggests a family enmeshment consistent with data showing that those with OCD tend to be celibate and have a low marriage rate (Hare, Price, and Slater, 1972). Thomsen (1995) followed up 47 childhood OCD patients 6–22 years after their first referral found that, compared with non-OCD patients, they had fewer partnerships and more were still living with their parents.

The overprotection that, in theoretical terms, underlies magical thinking, involves parents accommodating to the child's conception of others as extensions of self. As Kohut pointed out, parents must provide selfobject experiences for the child, but with maturation they must also fail in this behavior, providing "optimal frustration" and the experience of others as objects. A recent study from Calvorovessi et al (1995) suggests that such accommodation, at least of a kind, persists into adult life. They found that 30 of 34 families of an OCD sufferer accommodated to the patient's symptoms in a way that seemed unreasonable. Unfortunately, such data shed no light on the parents' behavior in the patient's childhood.

It appears that the child who eventually develops OCD, and who is overprotected, is treated, at least in some ways, as "special." The family remarked, for example, on Mr. A's "special" relationship with his mother compared with that between his brother and the mother. The coarse data of several studies support the notion of "specialness." For example, there are more male firstborns than expected in a sample of OCD patients (Snowdon, 1979). Significantly more parents of OCD patients belong to the highest social classes (Thomsen, 1994). There is some evidence that those with OCD are of above average intelligence (Slater, 1945; Lal, Gupta, and Agarwal, 1987). Contrary to the findings in other anxiety-based disorders, in which females predominate, OCD, in at least some studies, is more common in males (Swedo et al., 1989; Okasha et al, 1994; Hanna, 1995). However, in a large U.S. study (Karno et al., 1988) males and females are equally represented. It may be that excess male representation is a product of those cultures and subcultures in which maleness in children is highly valued. However, Janet's figures were strikingly different. He found a 3:1 ratio in favor of females (Pitman, 1984). Perhaps this is

a reflection of very different cultural norms in European society a century ago, when females were considerably more protected than they are at present.

Realization and Doubt

Treating a child as special is an essential aspect of his or her development. Kohut, for example, spoke of the adoration (Elson, 1987, p. 62) of the mother for her baby. However, the protection and the aura of "specialness" that surrounds the child who later develops OCD is of an unreal kind. In important ways it is not connected or related to central aspects of the child's personal reality. The effect of this lack of connection is to impede the emergence of inner experience and the sense of self.

Self is defined here in the manner of William James (1890). It is conceived as an awareness of the movements of an inner life, which have the form of play (Meares, 1990, 1993, 2000; Meares and Lichtenberg, 1995). It is a process, not a substance or a thing. (The frequently used term *structure* is more appropriately tied to self-representation.) Self as the stream of consciousness emerges rather late in development, around the age of 4 (Flavell, Green, and Flavell, 1993). It seems clear from a multitude of studies of parent–child interaction that the necessary precursors to this experience include significant periods of "attunement" (Stern, 1985) on the part of the parents to the most personal of the child's experience, the core of which is a feeling-state. In this way, the evanescent, partly formed inner zone is made "real." On the other hand, where this attunement is lacking, reality is uncertain. The way in which the caregiver helps in establishing the child's personal reality is illustrated by the interesting experiments of Sorce et al. (1985).

The responses of children aged about a year were studied as they crawled out over the visual cliff. At some point, as they moved out over the glass, they became aware of the space below them. They would then glance at their mother. If the mother showed fear on her face, the children were also afraid and scuttled back from the apparent cliff. On the other hand, if the mother smiled and was reassuring, then the baby continued moving toward her. The mother's expression gave shape to the child's reality.

We might suppose that the child, poised precariously over the space below it, was uncertain and had mixed feelings, including both apprehension and curiosity. The mother's expression can sometimes encompass several aspects of the child's feeling state. Often, she makes a choice of response. There is, however, a third possibility. She makes no response at all. What will be the effect? First, we presume, the child will wait, however briefly, for the mother to play her part in the child's experience. She is required, as it were, to complete it. If she continues to show no response, the experience has about it a feeling of being unfinished. Moreover, the child is now in two minds. Is this situation dangerous or merely interesting? How then should one act? The child's situation is now very like that of the sufferer from obsessive-compulsive disorder in which, as the early French descriptions of the disorder show, the sentiment d' incompletude and the folie du doute are central features. [In etymological terms, *doubt* refers to being in two minds (Partridge, 1983).] The individual's confidence in the reality of his or her experiences, including memories, is diminished (McNally and Kohlbeck, 1993).

In an early paper, Freud gave descriptions of obsessional states, which included the folie du doute (Freud, 1895). In his study of the Rat Man, it seemed central to an understanding of the disorder. Obsessionals doubt everything—the significance of their thoughts, the veracity of their feelings, the meaning of their acts, and their worth as people. The pervasive doubts are accompanied by repetitive internal questioning of the kind: "What if . . . ? How can I be sure?"

The centrality of doubt in OCD is accompanied by a fragility of meaning. Meaning was a preoccupation of the Rat Man. For example: "He forced himself to understand the precise meaning of every syllable that was addressed to him, as though he might otherwise be missing some priceless treasure" (1909, p. 190). Derealization is a common accompaniment of OCD, as Janet had pointed out (Pitman, 1984, p. 299).

Freud viewed obsessive doubt as a kind of need. He wrote that "the creation of uncertainty is one of the methods employed by the neurosis of drawing the patient away from *reality* and isolating him from the world" (1909, p. 232). What is suggested here is the reverse proposition. The individual's disconnection and isolation from the world produces a diminished sense of reality.

The lack of attunement to the child's experience seems, in the case of those with OCD, to amount to more than empathic failure. It involves actual evasion of central issues of family life. A facade of genteel "niceness" is maintained while these issues are skirted about, not spoken of. The sense is conveyed that conversation about these issues might, in some way, be beyond what the child can cope with. An example was provided by Miss E, who, as previously remarked, still slept in her mother's bedroom at the age of 23. A major event in her childhood was the separation of her parents, which occurred when she was 4. Her parents, however, in order to "protect" the child, tried to pretend that the marriage was continuing as before. The father visited every weekend in order to preserve an appearance of "normal" family life. It wasn't until the child was 16 that she learned the truth. A similar story of a family skirting about central issues in the developing child's life was given by another young woman. Her father had died when she was a child, but she was never given any proper explanation of what had occurred. She knew he had "gone to rest" and believed that one day he would come back and that she would see him walking in the street. Additionally, the family avoided the issue of sexual abuse, which had been inflicted upon the child by a family member and which, the patient sensed, the family knew about.

This kind of behavior was discussed by Calvocoressi et al. (1995) in their study of parental accommodation to OCD behavior. These investigators considered that the accommodation was a means of avoiding unpleasantness; that is, it was intended to reduce the patient's anxiety or anger. However, it was Joseph Barnett who most clearly described the characteristic familial system in OCD. Influenced by Sullivan (1956, p. 267), he observed that "the obsessional way of life is largely organised to meet the dilemma created by the hypocrisy and ambiguity characteristic of the obsessional's early family situation. The self system of the obsessional develops in a climate of hostility, rejection, and power struggles hidden beneath a facade of loving care and concern. In lieu of warmth and acceptance, he was the object of overprotective and restrictive demands" (Barnett, 1971, p. 338). Typically, despite its dysfunctional nature, the marriage of the parents persists (Thomsen, 1994). Their avoidance of crucial aspects of their own and their child's existence, amounting at times to deception and self-deception, is internalized by the child, leading Barnett to define the central dynamic of the obsessional is a conclude

that need to maintain innocence, that is, a need not to know about himself or herself or about his or her relationships.

Apathy, Trauma, and the False Self System

The failure of the parents to respond adequately to a child's personal reality has consequences beyond the "need not to know." First of all, it has an effect on the child's sense of vitality.

The issue of vitalization provided by the responsiveness of caregivers is vividly illustrated by Mahler et al. (1975). They described a situation "in which the 5–8 month old, surrounded by the admiring and libidinally mirroring, friendly adults, seemed electrified and stimulated by the mirroring admiration. This was evident by his excited wriggling of his body, bending his back to reach his feet and his legs, kicking and flailing with the extremities and stretching with an exaltedly pleasurable affect" (p. 221). Such an enlivening effect of the caregivers' behavior involved a "fit," or matching, between the child's main experience and the response of the other. The sense of "fit" experienced, at times, between oneself and others is, of course, found throughout life and accompanied by a feeling of well-being (Meares, 1977, 1993, 2000). Those relatively deprived of this form of responsiveness may be left not only with a persisting dysphoria, but also a diminished feeling of vitality.

Lack of connectedness between parent and child and the habitual empathic failure displayed by the former have an effect on the developing individual which at times is traumatic. Trauma is understood here as "a break-up of whatever may exist at the time of a personal continuity of existence" (Winnicott, 1974, p. 115).

Traumatic events are stored in a memory system that, it has been postulated (Meares, 1995), develops earlier in the child's life than those memory systems upon which ordinary mature consciousness depends. The traumatic memory system has been delineated by Brandchaft (1993), who points out that it is activated, as if automatically, by contextual cues. It is repetitive and beyond the reach of reflective processes. In this sense, it is "unconscious." The contents of this system are malignant, telling the patient, for example, that he or she is bad, useless, ugly, stupid, or the like. These depreciatory and derogatory self-attributes are linked to attributes of the other, which are also negative and involving such features as control and accusation. Allied to these negative attributions are negative affects,

often involving intense hostility and a vengeful wish to harm. Activation of this system, once again, knocks out the experience of self.

The traumata impacting on children through their sense of disconnection from an attachment figure are equivalent to mini-abandonments. As previously remarked, separation fears seem to be fundamental to the dynamics of OCD. The traumatic memory system is often triggered in an overwhelming way by life events such as bereavement (Khanna et al., 1988), which evoke these fears, precipitating the illness. Threats to health, which are linked to separation fears through their association with death, are other important precipitants (Khanna et al., 1988). Warfare provides an extreme example of such a threat. Pitman (1993) points out that a disproportionate rate of OCD is found among high combat-exposed Vietnam veterans.

With the onset of the illness, the traumatic life event appears, at times, as if it were the primary trauma, whereas it has fallen, as it were, into a preexisting lacuna of the psychic system. Mr. A's illness, for example, was precipitated by his wife becoming pregnant, despite Mr. A's wishes that they have no children. Mr. A, a firstborn child who, a relative said, had been given "unbelievable, perhaps excessive" family support, feared that he would harm the child and was afraid to pick it up. The child evoked separation fears, which had their origin earlier in life.

Mrs.G's history was very similar. She too could not pick up knives or sharp objects that might harm her newborn child. She too felt the child threatened her dependency needs. Magical thinking caused her to fear that her hostility would cause actual harm to her child. After some weeks in therapy she spontaneously began to talk of a life alone and of the possibility that her husband might leave her.

The fears of abandonment, which lie at the heart of OCD, have a major affect in shaping the personality of the future patient. Children driven by separation fears will behave in any way that maintains the attachment bond. Spontaneous expressions and behaviors are sacrificed in favor of those that seem likely to gain parental approval. Such behaviors and expressions will, at times, override the actual emotional state of the child. Since that emotional state has somatic accompaniment, the child's behavior is cut off from the aliveness of body feeling. The resultant sense of deadness compounds the devitalization that is a consequence of repeated empathic failure

(Meares, 1993). The individual senses that his or her ordinary living with others is false and unauthentic.

Barnett considered that the compliant "false self" (Winnicott, 1960) was typical of the child who was vulnerable to the later development of OCD. Barnett (1971) wrote: "Parental approval was predicated upon the degree of the child's conformity to parental needs and expectations, disregarding or exploiting the needs, feelings and capabilities of the child. He was caught, therefore, in the paradox that he was most approved of when he was least himself or for himself" (p. 338).

Personality Disorder

The disruptions of development described so far will, in many cases, lead to the diagnosis of personality disorder in adult life. However, this personality disorder is unlike that traditionally associated with OCD, namely, obsessive-compulsive personality disorder. Black et al. (1993) found that, although personality disorder is common in OCD, their data did not support a relationship between OCD and compulsive personality. Their conclusion was consistent with the findings of Baer et al. (1990), who detected obsessive-compulsive personality disorder in only 6 percent of their patients.

The typical form of personality disorder underlying OCD has characteristics that can be inferred from the foregoing description of the family background of the OCD patient. These characteristics are largely in accord with the observations of Joffe, Swinson, and Regan (1988) on 23 patients with OCD. They found that a mixed personality disorder with avoidant, dependent, and passive–aggressive features was frequently observed in this group, whereas compulsive personality was uncommon. Such studies, based on preexisting schemata, have the disadvantage of not recording phenomena that are not expected. Nevertheless, such labels as "avoidant," "dependent," and "passive–aggressive" resonate with clinical descriptions. Janet gave particular emphasis to the avoidant features. He considered that timidity was a feature of the antecedent personality of OCD (Pitman, 1984). "Their parents are controlling and prevent them from confronting any dangers, emphasising prudence and abstention. John's maid accompanied him to school until he was 18, hence he became a laughing stock among his peers" (p. 291).

It is of interest that Janet also confirms the observations made earlier in this paper but which are not considered in studies of personality depending on DSM. He identified a form of false self-system in these patients. "The joy of causation is lacking and the patient may feel that he is playing a role rather than acting sincerely" (Pitman, 1984, p. 298). To this state is allied passivity and "a certain pleasure from obedience" (Pitman, 1984, p. 301).

The Wolf Man: Diagnosis

The upbringing and personality of Freud's famous case, the Wolf Man, illustrate the data and hypotheses regarding OCD presented so far. However, before touching upon aspects of his biography, it is necessary to consider the Wolf Man's diagnosis, since some controversy surrounds it.

Both Blum (1974) and Buckley (1989) consider that the Wolf Man had a borderline personality. In my view, the evidence of such a diagnosis is insufficient to meet current criteria. Moreover, his early life is quite unlike the chaotic and often abusive childhood of the typical borderline (Herman, Perry and van der Kolk, 1989). Nevertheless, their suggestions are consistent with the notion that a personality disorder provides the necessary matrix from which OCD might emerge. They also accord with data that show cluster B traits in association with OCD (Baer et al., 1990; Nestadt et al., 1994).

The evidence for OCD as provided by Freud seems, at least to me, convincing. The Wolf Man told him that as a child, he performed a ritual that was apparently designed to overcome anxiety about falling asleep caused by his fear of bad dreams (Freud, 1918):

> Before he want to sleep he was obliged to pray for a long time and to make an endless series of signs of the cross. In the evening, too, he used to make the round of all the holy pictures that hung in the room, taking a chair with him, upon which he climbed, and used to kiss each one of them devoutly. It was utterly inconsistent with this pious ceremonial—or, on the other hand, perhaps it was quite consistent with it—that he should recollect some blasphemous thoughts which used to come into his head like an inspiration from the devil. He was obliged to think "God–swine" or "God–shit." Once while he was on a

> journey to a health resort in Germany he was tormented by the obsession of having to think of the Holy Trinity whenever he saw three heaps of horse-dung or other excrement lying in the road. At this time he used to carry out another peculiar ceremonial when he saw people that he felt sorry for, such as beggars, cripples, or very old men. He had to breathe out noisily, so as not to become like them; and under certain conditions he had to draw in his breath vigourously [pp. 16–17].

The magical thinking involving the beggars and cripples seems to show the operation of both Fraser's Law of Contagion and that of Imitation. The frank manifestations of OCD, according to Freud's chronology (Freud, 1918, p. 121), were apparent between the ages of 8 and 10.

The second illness, which was treated by Ruth Mack Brunswick, was described by her as

> a hypochondriacal *idée fixe*. He complained that he was the victim of a nasal injury caused by electrolysis, which had been used in the treatment of obstructed sebaceous glands of the nose. According to him, the injury consisted varyingly of a scar, a hole, or a groove in the scar tissue. The contour of the nose was ruined. Let me state at once that nothing whatsoever was visible on the small, snub, typically Russian nose of the patient. And the patient himself, while insisting that the injury was all too noticeable, nevertheless realised that his reaction to it was abnormal [Brunswick, 1971, p. 264].

Brunswick considered that this ideation was delusional and related to a paranoid state. It is of interest, in this regard, that the Wolf Man's paternal uncle was institutionalized with a paranoid disorder (Gardiner, 1971a, p. 13). However, the Wolf Man's recognition of the abnormality of his preoccupation suggests that his ideation was not delusional.

This is not to say that a paranoid state may not be closely relation to an obsessional illness (Meares, 1988) nor that the distinction between delusion and obsession is always clear. Nevertheless, the Wolf Man's behavior suggested that he was afflicted with a "somatic obsession." Brunswick wrote:

> He neglected his daily life and work because he was engrossed, to the exclusion of all else, in the state of his nose. On the street he looked at himself in every shop-window; he carried a pocket mirror which he took out to look at every few minutes. First he would powder his nose; a moment later he would inspect it and remove the powder. He would then examine the pores, to see if they were enlarging, to catch the hole, as it were, in its moment of growth and development. Then he would again powder his nose, put away the mirror, and a moment later begin the process anew. His life was centred on the little mirror in his pocket, and his fate depended on what it revealed or was about to reveal [Brunswick, 1971, p. 265].

In modern terminology, the Wolf Man's diagnosis, on this occasion, might be body dysmorphic disorder. This condition is characterized by a preoccupation with an imagined or slight defect in appearance. The available data suggest that this illness is an obsessive-compulsive spectrum disorder (Phillips et al., 1995). Simeon et al. (1995), in a study of 442 patients with OCD, found that 51 had a lifetime comorbid history of body dysmorphic disorder. It would seem such a diagnosis is consistent with Freud's earlier diagnosis of OCD.

The Wolf Man: Development and Personality

The Wolf Man's case is well known, and the details need not be repeated here. However, the bare bones of his biography are as follows. The Wolf Man first came to see Freud in 1910. He was 23 at the time. He came from a very wealthy Russian land-owning family. His only sibling was an elder sister, 2½ years older than himself, who committed suicide in 1906. His father died suddenly in 1908 at the age of 49. The Wolf Man suspected that the death may have been cause by an overdose of sleeping medicine. At about 4, he experienced the terrifying dream of wolves, which gave him his name. This appeared to be a precursor to the later development of OCD. In his twenties he suffered rather vague depressive symptoms, which eventually brought him to Freud. He was treated by Ruth Mack Brunswick between 1926 and 1927. By this time the Wolf Man's life had remarkably changed. He had lost the family fortune and vast estates in the Russian Revolution of 1917. Following recovery from

the illness treated by Brunswick, he remained fairly well for the rest of his life, leading a very restricted existence in Vienna and living to a great age. His own biography, together with the observations of Freud, Brunswick, and Muriel Gardiner, reveal a picture in which overprotection and dependency are prominent features. In addition, it shows the related egocentrism (in the Piagetian sense); "specialness"; apathy, passivity and obedience; compliance leading to a false self system; lack of a sense of connectedness with others; derealization; and also "hypocrisy."

The Wolf Man's severe dependence was apparent when he first saw Freud. He travelled with his own physician and orderly, was entirely dependent upon others, could not dress himself, and was unprepared for any kind of work. Later, in treatment, Freud (1918) found his "shrinking from a self sufficient existence" remarkable Freud, 1918, p.11).

The background to this state of dependence was one in which the protective care of the child was given over to servants. The Wolf Man wrote, at the end of his life, "As our parents were often away, my sister and I were left mostly under the supervision of strangers, even when our parents were home we had little contact with them" (Gardiner, 1971a, p. 8). His mother, he remarked, "was so concerned about her health, she did not have much time left for us" (Gardiner, 1971a, p. 9). The most important caregiver was his Nanya, a devoted peasant woman, whose own child had died and who transferred all her maternal affection upon the isolated only son of her employers. Of this isolation, the Wolf Man later remarked that his elder sister was his only companion.

Muriel Gardiner remarked that his feeling of being "superfluous" was a theme the Wolf Man often touched upon. His sense of disconnection was profound. He wrote to her: "I think indeed that the deeper cause of every neurosis and every depression must be the lack of relationship to the world around one, and the emptiness which results from this" (Gardiner, 1971b, p. 351).

A system of dependence that was initiated in his early days was maintained for him in various ways for the rest of his life.

He married a beautiful nurse whom he had met in a period before he went to Freud, during which for some time he was in a sanatorium suffering from a vague depression. The nurse, Therese, came from a family who had lost all their money. She herself had had a failed

marriage, during which she had had a child. Her daughter, Else, was 4 when Therese met the Wolf Man. After resisting his initial advances, Therese eventually agreed to marry him. From the Wolf Man's own account, it is clear that he expected her to adapt to him and to his style of living. He wondered whether someone who was very poor, had no parents, and was German, would be able "to adapt herself to life in our family circle and in surroundings completely alien to her." Therese herself realized that she must adapt and that in this way she sacrificed herself. This intuition is apparent in the Wolf Man's account of their marriage: "Soon after her arrival in Odessa we got married. On our way home in the carriage Therese grasped my hand, kissed me and said with a lump in her throat, 'I wish you great happiness in your marriage.' These words struck me as strange. Why did she speak of your marriage, instead of our marriage, just as if I had not married her but another woman" (Gardiner, 1971b, pp. 95–96). Her adaption to his needs involved her abandoning her daughter to relatives. The marriage had been in 1914. Sometime in 1915–16 news was received from Germany that Else had fallen ill with pneumonia. "Therese reproached her relatives in whose home Else was living for not taking care of the child, and tortured herself with self reproaches for not having fulfilled her duty as a mother and for having sacrificed Else for me." It is clear that this sacrifice was not necessary in terms of any financial difficulties since the Wolf Man was immensely rich. We presume that in some way he may have conveyed to Therese the idea that he required all her care.

Despite Else's illness, nothing was done about the child. In 1918 the news arrived that the pulmonary disease from which she suffered was not pneumonia but tuberculosis and that she was not expected to live. Once again, the Wolf Man seemed unable to comprehend the distress his wife might be likely to be suffering. She left for Germany in September 1918. Before she departed, he had accompanied his wife to the German Consulate in order to get a visa and was asked if he too wanted a permit. He had not thought of it. "Although I had originally not considered it, I answered in the affirmative" (Gardiner, 1971a, p. 102). He accompanied her only to Kiev and did not see her or her daughter again until May 1, 1919. He was shocked to discover that Therese's beautiful black hair had now turned snow white, he presumed from grief (Gardiner, 1971a, p. 110). Else died 2½ months after his arrival.

The Wolf Man's relation to Therese was egocentric, in the Piagetian sense, in that he appeared to be unaware that she might have feelings that were uniquely hers. The sense of living in an entirely personal universe persisted into his later years. It is implied by the description of Dr. F. Weil, who met the Wolf Man in 1949. Dr. Weil was impressed "by the Wolf Man's absorption in himself to the exclusion of all else" (Gardiner, 1971, p. 363). Muriel Gardiner, visiting him in Vienna in 1938, was struck by the fact that "he seemed unaware of events about him, even to the extent of scarcely knowing the Nazis were in power" (Gardiner, 1971b, pp. 312, 345–346).

Therese cared for the Wolf Man devotedly for the rest of her life. He became completely dependent upon her so that Ruth Mack Brunswick remarked, "My patient . . . was completely under the control of his wife: she bought his clothing, criticised his doctors, and managed his finances" (Brunswick, 1971, p. 282).

In 1938 she killed herself. Unknown to him, she had been having suicidal thoughts for at least a year. She left him sad, devoted farewell letters. Almost immediately, he left for Paris and London in order to see Ruth Mack Brunswick. Some weeks later, he returned to Vienna, having arranged for his mother, who was now living in Prague, to move into his apartment. He also arranged for a devoted servant, Fraulein Gaby to do his housekeeping. Later, she took care of "all the little every day matters of his life" (Gardiner, 1971b, p. 324).

The Wolf Man was able to recreate this system of dependence with Freud. Following the loss of his estates in Russia he no longer had a private income. Nevertheless, he had no children and was able to work, as he demonstrated for the rest of his life in Vienna. Freud, however, arranged a collection of a sum of money for him from the psychoanalytic group and repeated this collection every spring for 6 years (Brunswick, 1971, p. 266). The Wolf Man, it seems, had created a countertransferential atmosphere, suggesting he was "special" and uniquely requiring of care.

The Wolf Man's acceptance of Freud's financial support, Brunswick discovered, involved something akin to self-deception. She found that, at the time Freud was raising money for him, he was in possession of jewels, which the Wolf Man thought, at the time, were worth thousands of dollars. Brunswick remarked that her patient's "attitude was one of hypocrisy" (Brunswick, 1971, p. 280). She was struck by the fact that "the man who presented himself was guilty of innumerable minor dishonesties: he was concealing the

possession of money from a benefactor with whom he had every reason to be candid. Most striking of all was his total unawareness of his own dishonesty" (Brunswick, 1971, p. 279).

It seems that the Wolf Man simply considered the support was his "due" (Brunswick, 1971, p. 282). He implied a special relationship with Freud. Brunswick's technique consisted in an attempt to "undermine" the patient's sense of specialness and "the patient's idea of himself as the favourite son" (Brunswick, 1971, p. 284). Following her confrontations, "he was obliged to admit that he had never met Freud's family. His replies were vague and unsatisfactory, perhaps even to himself. His arguments had an extraordinary tone: they were not exactly specious, but they contained an astounding mixture of fantasy and fact" (Brunswick, 1971, p. 284).

The "hypocrisy" that Brunswick found in her patient is an echo of the description of the familial background of OCD given by Barnett. There is not enough evidence to support strongly the view that the Wolf Man's early life was characterized by a failure of the caregivers to address essential and important feelings in the child's life at the time or by a tendency to skirt about anxieties as if the child might not be able to deal with them. Nevertheless, he does recount one episode occurring in his adult life, which is characteristic of such a family environment.

Having married Therese, he took her back to the Russian estate where difficulties were immediately created by the behavior of a young woman named Lola who was married to the Wolf Man's younger cousin. It was discovered later that this marriage was asexual. Lola behaved in an openly provocative and seductive manner toward the Wolf Man, which upset Therese. The Wolf Man understood from Therese's response that the presence of Lola in the house was likely to undermine his marital relationship. Compelled to do something, he approached his mother. "I decided to talk openly with my mother about the situation. However, my mother would not enter into a discussion, but simply tried to calm me down and to make the whole affair appear harmless and unimportant" (Gardiner, 1971a, p. 97). This is a relatively minor incident, but it may reflect the way in which the Wolf Man was treated. The source of an anxiety was evaded and the pretense maintained that everything would be all right.

The "hypocrisy," however, that Brunswick encountered went beyond the deception relating to the jewels. It involved the compliant false self-system. "He talked at great length about the marvels of

analysis as a science, the accuracy of my technique, which he professed to be able to judge at once his feeling of safety being in my hands, my kindness in treating him without payment, and other kindred topics" (Brunswick, 1971, p. 280). It seemed that he was trying to provide for her what he supposed she wanted. The result was that Brunswick felt she wasn't getting anywhere. He was impermeable. The first dream was a replay of the famous Wolf Dream. In the new version, however, the wolves, formerly white, were now grey. Many others, "mere installments," followed (Brunswick, 1971, p. 280). He was invulnerable on important topics but "brought the clearest dreams in order that I might show my skill in interpreting them, thus confirming his statement that he was better off in my hands than in Freud's" (Brunswick, 1971, p. 283).

Meissner considers that the Wolf Man's behavior with Freud was also of a false self kind. In Meissner's view, he presented "a compliant and analytically productive false self that served to satisfy Freud, yet left the inner realm of introjective grandiosity untouched. The Wolf Man gave Freud what he was looking for, and in return he received the benign accolades and approval from Freud that a part of him, even behind the rigidly defensive facade, had continually yearned for" (Meissner, 1979).

Freud became a major figure in the Wolf Man's life, seeming to become an idealized selfobject. It seems not unlikely that his realization of the serious nature of Freud's illness in the latter half of 1923 was a precipitant of the illness that Brunswick treated and that began in February 1924.

Like Freud, who commented on his patient's entrenchment "behind an attitude of obliging apathy," Brunswick noted the Wolf Man's passivity and submissiveness (pp. 292–293). However, his passivity had a controlling element in it, at times. He refused to discuss certain topics and in many areas remained walled-off (Brunswick, 1971, p. 280). The origins of a traumatic system of the kind referred to earlier in the paper were apparent in the Wolf Man's autobiography. He described an incident involving a little accordion,

> which was given to me when I was about four years old, probably as a Christmas present. I was literally in love with it, and could not understand why people needed other musical instruments, such as a piano or a violin, when the accordion was so much more beautiful.

> It was winter, and when darkness fell I sometimes went to a room where I would be undisturbed and where I thought nobody would hear me, and began to improvise. I imagined a lonely winter landscape with a sleigh drawn by a horse toiling through the snow. I tried to produce the sounds on my accordion which would match the mood of this fantasy.
>
> Unfortunately these musical attempts soon came to an end. One time my father happened to be in an adjoining room and heard me improvising. The next day he called me into his room, asking me to bring along my accordion. On entering, I heard him talking to an unknown gentleman about my attempts at composition, which he called interesting. Then he asked me to play what I had been playing the previous evening. This request embarrassed me greatly because I was unable to repeat my improvisations "on command." I failed miserably and my father angrily dismissed me. After this painful failure I lost all interest in my beloved instrument, left it lying around somewhere in my room, and never touched it again [Gardiner, 1971a, p. 10].

A repetition of such parental behavior might lead him to a need to "wall off" particular areas of psychic life so that core aspects of a personal reality remain beyond the risk of damage (Meares, 1976). It would seem that none of the Wolf Man's caregivers, with the possible exception of his Nanya, had the capacity to respond appropriately to his emergent sense of self. After an unsatisfactory English governess, a Bulgarian followed. At the age of 5, a new governess was appointed. "Like most elderly spinsters she was inclined to be domineering." He and his sister "spent the whole day under her influence" (p. 15). This woman, "Madamoiselle," was Swiss. Her

> principal object of education was to teach her pupils good manners and etiquette. As she had spent decades in Polish families,she spoke a mixture of mutilated Polish and Russian words, which however sufficed to make her understood by those around her. Of course Madamoiselle taught us French also. She would start to explain something, jump from on subject to another, and then begin to reminesce endlessly about the days of her youth [Gardiner, 1971a, p. 16].

Such a person seems unlikely to be able to respond empathically to the small child's nascent inner world of feelings and imaginings. The Wolf Man's sense of disconnection from others, as he intimated to Gardiner late in life, must have been profound. There was nobody who could make "real" the central aspects of his existence. Consequently, derealization was among his most prominent symptom on entering a sanatorium in Munich in 1908. "I had found life empty. Everything seemed 'unreal' to the extent that people seemed to me like wax figures all wound up, marionettes with whom I could not establish any contact" (Gardiner, 1971, p. 50).

Concluding Remarks

This paper elaborates the hypothesis that the principal features of OCD have their origin in the patient's immature conception of the boundedness of self (Meares, 1977, pp. 63–79; Meares, 1994), so leading to the "omnipotence of thoughts." The predisposition to magical thinking is understood as the consequence of an upbringing that failed to foster the different experiences of both inner and outer zones. Severe overprotection impedes the emergence of the concept of objects and the external environment; failure to connect with, and so make "real," core aspects of the child's personal experience hinders the genesis of a nascent inner life. The developing individual remains relatively egocentric, in the sense that he or she inhabits a largely personal universe. The consequence of these specific deficiencies of the caregiving environment is the development of a particular kind of personality disorder, the central characteristics of which are timidity and falseness. The story of the Wolf Man is consistent with this general schema.

OCD is likely to be a heterogeneous disorder. Baer (1994) factor analyzed the clinical features of 107 patients and found three main groupings of symptoms. These factors were named "symmetry/hoarding," "contamination/cleaning," and "pure obsessions." Only the first factor was significantly related to comorbid obsessive-compulsive personality disorder or to a lifetime history of Tourette's syndrome or chronic tic disorder. These subtypes of OCD may have different natural histories. Janet noted that in those relatively rare cases, (about 5 percent in his own series of over 300), which have their onset in the form of tics, the course was an "unhappy" one

(Pitman, 1984, p. 310). This paper has been concerned with the second subtype, that is, "contamination/cleaning."

The ideas put forward here have therapeutic implications that are beyond the scope of this paper. Some of them, including the need to foster the sense of the privacy of self and the "ownership" of thought (Meares, 1986) have been touched upon elsewhere (Meares, 1994). Brandchaft describes, in this issue, the approach to the developmental impediments and the traumatic memory system. The therapist will be required to adopt forms of behavior that differ from the traditional, as Freud demonstrated in instituting a time-limited therapy (Gardiner, 1971, p. 157). The need to be "real," in a particular way, is implied in Ruth Mack Brunswick's description of her treatment and made explicit by Barnett (1971). Finally, the therapist must not neglect the significance of action. His or her encouragement of "action as choice" (McMurray, 1957, p.1 39) is significant in helping the patient take those "risks" that are necessary steps on the path to recovery.

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