Psychoanalysis and General Psychiatry:
Obsessive-Compulsive Disorder as Paradigm
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ABSTRACT
To certain areas once dominated by psychoanalytic conceptualizations of psychopathology and pathogenesis, general psychiatry has in recent years made significant contributions. The obsessive-compulsive disorder is cited as an example, and illustrations of such contributions are described and discussed. Some implications for psychoanalytic theory and research are suggested.

FREUD (1926) SPOKE OF "OBSESSIONAL NEUROSIS" as "the most interesting and repaying subject of analytic research. But as a problem," he wrote, "it has not yet been mastered" (p. 113). Sixty years later we are in the same position. The problem of obsessional neurosis—or in the DSM III classification, obsessive-compulsive disorder—remains not only unmastered, but appears increasingly complex theoretically and at least equally frustrating therapeutically. Despite its inherent fascination, little has appeared in the psychoanalytic literature in recent years that has substantially advanced our understanding of this once prototypic neurosis. Indeed, since the 1965 Congress of the International Psychoanalytical Association, whose discussions were concisely summarized by Anna Freud (1966), no systematic discussion of the topic has been published in the psychoanalytic literature, nor has the American Psychoanalytic Association devoted a panel to the subject.

At the same time, general psychiatry and behavioral psychology have made significant inroads into both the understanding and treatment of this disorder. What was seen, since Freud's (1909) publication of the Rat Man case, as a paradigmatically psychogenic illness is now viewed as, at the least, multiply determined, with components of neurobiology, learning and conditioning and conflictual elements synergistically involved.

I shall briefly review the psychoanalytic literature on obsessive-compulsive disorder, emphasizing work of the past two decades. I shall also review some recent contributions from other disciplines, suggesting ways in which they may influence psychoanalytic views and necessitate changes in the psychoanalytic concept of the disorder.

Psychoanalytic Contributions
The locus classicus for the formulation of the structure of obsessive-compulsive disorder is, again, Freud's (1909) Rat Man case. In this remarkable case presentation (and the clinical footnotes) Freud delineated some of the abiding notions about obsessional dynamics: the central role of ambivalence; the regression from unresolved oedipal conflicts to anal-sadistic concerns with control; the salience of defenses of reaction formation, intellectualization, isolation, and undoing; and the critical importance of magical thinking. He carried these thoughts further in "The Disposition to Obsessional Neurosis" (1913) in which he formulated the concept of the pregenital organization of the libido—determined, he suggested, primarily by constitutional rather than experiential factors, and crucial to the obsessional neurosis as the locus of
recession when genital sexual organization failed or had to be relinquished: "hatred and anal erotism," he said, "have ... taken over the representation of the genital instincts" (p. 321) in such cases. Obsessional neurosis "usually shows its first symptoms in the second period of childhood (between the ages of six and eight)" (p. 318); in such instances "the sexual organization which contains the disposition to obsessional neurosis ... is never afterwards completely surmounted" (p. 322). Freud correlated obsessional neurosis and obsessional character. In the latter, the "regression following repression ... has occurred smoothly," while "in the neurosis there are conflict, an effort to prevent regression ... the reaction-formations against it and symptom-formations produced by compromises between the ... opposing sides ..." (p. 324). Significant is a dissynchrony between ego development and libidinal development; precocity in the former encourages recession and the development of obsessional defenses.

Much of this is repeated in "Inhibitions, Symptom and Anxiety" (1926), but here Freud adds references to the "severe" and "unkind" character of the superego, determined also by the regression from the more mature superego characteristic of the genital organization. He defines the special role of the defenses of undoing and isolation in the obsessional, and notes that although obsessional ideas are conscious, they are disguised and distorted substitutes for the unconscious impulse which is being warded off.

Since Freud's definition of the basic conflicts and defensive structure of the obsessive-compulsive, subsequent contributions by others have been little more than elaborations of or glosses on his fundamental ideas. Abraham (1924) considered obsessive-compulsive neurosis as a variant mode of the anal-sadistic organization of the libido, contrasting it with melancholia. In the former, the emphasis is, he suggested, on the retaining-controlling aspects; in the latter, the emphasis is on the more primitive-destructive aspects of this stage of development, fixation or regression. Earlier, Ferenczi (1913) had addressed the omnipotent thinking of the obsessional, explaining it as a sign of regression to an early stage of the development of the sense of reality—the stage of "magic thoughts and magic words."

Weissman (1954) addressed the characteristics of the superego in obsessional character and obsessive-compulsive neurosis—conforming to the common psychoanalytic view that the two are essentially identical in structure and that the latter develops out of the former by processes of regression and secondary defense formation. Weissman elaborated on Freud's distinction between the severe primitive, or in Weissman's terms, "archaic" superego of the obsessive-compulsive neurosis and the "mature" superego of the normal person and the obsessive-compulsive character. Libidinal regression to anality in the face of the "archaic" superego leads to neurosis, while similar regression in the face of a "mature" superego leads to obsessional character formation; at the same time the ego regression in obsessive-compulsive neurosis is greater than in obsessional character.

The principal reassessment of classical views on obsessive-compulsive neurosis can be found in Anna Freud's (1966) summary of the discussions at the 1965 Congress of the International Psychoanalytical Association. She espoused prevalent views of the continuity between obsessional character and obsessive-compulsive neurosis, of the primary role of impulses of the pregenital (i.e., prephallic) anal-sadistic stage and the familiar catalog of defenses. She differentiated between obsessive-compulsive phenomena and both the "pre-ego" repetitions of young children and mental defectives and the "compelling" impulsive behaviors of addicts and delinquents. She underscored the central importance of ambivalence (or lack of drive fusion). "Constitutional" factors, including inheritance, are important in determining not only the "intensity of anal-sadistic tendencies" but also the "preference" for the characteristic defense mechanisms.
Miss Freud devalued efforts at finding determinants of obsessive-compulsive disorder in early infant development; events at this stage were likely to be etiologically nonspecific as opposed to fixations related to anal phase development and to regression due to phallic-oedipal conflicts. The interactions between drive and ego as they relate to regression and defense organization are complex and not fully understood. In the end, little was added by the discussions at the Congress or by Miss Freud's comprehensive summary to well-established classical concepts.

The past two decades have, in their turn, added little more. Nagera (1978) treated the subject in a book-length treatise that essentially summarized Freud's views and those of later commentators, adding a "developmental approach" that remained rooted in libido theory and familiar concepts of anal sadism and regression. In the "interpersonal" literature, Salzman (1985) and Mallinger (1984) have emphasized the centrality of the obsessional's need for "control" in all aspects of life. As Salzman (1985) puts it, "the obsessive compulsive dynamism is a device for preventing any feeling or thought that might produce shame, loss of pride or status or a feeling of weakness or deficiency whether such feelings are aggressive, sexual, or otherwise" (p. 13). These authors subscribe to the view that obsessional character and obsessive-compulsive neurosis are on a spectrum and that the neurosis is the outcome of a breakdown of the adaptive defenses leading to the mobilization of secondary pathological "security measures." Developmentally, the basic need for control may be the consequence of the child's effort to cope with both "interpersonal dangers," such as parental inconsistency and unreliability, and "miscellaneous" external dangers (Mallinger, 1984). Most recently Munich (1986) has described the eruption of frank obsessive-compulsive symptoms in the course of analysis of a patient with an obsessional personality disorder. On each occasion the transitory symptom formation was precipitated by the emergence of material related to issues of separation and loss, triggering regression from oedipal to preoedipal longings and defense organization.

A special literature exists with regard to obsessive-compulsive neurosis in childhood, where difficulties in application of classical adult-derived categories complicate diagnosis and dynamic understanding. Despert (1955) defines the differences between severe obsessive-compulsive neurosis and "schizophrenia" in children, relying primarily on the intactness of reality testing and the ego-alien quality of the symptom to support the former diagnosis. In her view, obsessive-compulsive neurosis is "not so rare as noted in the literature" (p. 240), and its onset may "be considerably earlier (5 or 6 years level) than generally reported" (p. 252). In her discussion of Despert's paper, M. S. Mahler emphasizes the "pivotal" importance of the retention of object relations. "If this can be objectively or clinically ascertained, the case in question cannot be called psychotic" (p. 286).

Sandler and Joffe (1965) describe obsessive-compulsive neuroses in children, differentiating them from obsessive symptoms that arise in the course of anal-phase development, and persist. These, they say, are not, strictly speaking, neurotic "because they occur during the course of progressive development rather than as a consequence of regression" (p. 428). Wulff (1951) takes a similar position, stating that "preoedipal" obsessive-compulsive symptoms are reactive to external influences, rather than the outcome of intrapsychic conflict. Like others, these authors distinguish both these and truly neurotic obsessive-compulsive symptoms from symptoms that serve to deal with threats of annihilation and disintegration in borderline and psychotic children, and from repetitive behaviors in post-traumatic disorders. The emphasis of their discussion is on the role of regression in the ego, in particular, its defensive organization, in addition to the drive regression emphasized in earlier writings.

Most recently, the very existence of obsessive-compulsive neurosis in children has been questioned by Yorke and Burgner (1980) who contend that "we [should] speak only of obsessional tendencies and obsessional phenomena in children."
their view, the developmental line from primary bodily discharge to mentalization and the development of signal anxiety has not been sufficiently traversed by children (prior, presumably, to adolescence) to permit the formation of a true obsessional neurotic structure. Their conception of the dynamics of the "phenomena" they do observe does not differ significantly from the traditional one.

On the other hand, Judd (1965) in a review of 405 child patients found five clear cases of obsessive-compulsive disorder. Their average age of onset was seven and one-half, conforming with Freud's figures. Though all showed typical features of superego rigidity, ambivalence, and guilt reactions, their histories indicate no special difficulties with toilet training. Hollingsworth et al. (1980) report 17 cases conforming to strict diagnostic criteria in a large child guidance clinic over a span of 16 years. Average age of onset was 9.6 years, and 82 percent of parents suffered from severe psychopathology, not further specified. These authors conclude that the obsessive-compulsive symptoms in their cases represent efforts at defense against reality stresses in the family, encouraged by identification with the verbal/obsessive cognitive style of the parents. Symptoms tended to persist on long-term followup.

Nonanalytic Contributions

Behavioral Psychology

Learning theorists and behavioral psychologists have long been interested in obsessive-compulsive neurosis. In his literature review, Carr (1974) proposes that the distinction between "obsessions" and "compulsions" is irrational; the same etiologies appear to apply to both. He suggests that "compulsion" be used as the generic term, preceded by "cognitive" and "motor" to specify the observed content. Discarding simple learning and conditioning models as well as the psychoanalytic one, he concludes that compulsive behaviors are dependent on anxiety and that overt symptoms serve to reduce it. The essence of the psychology of the compulsive neurotic is that "in all situations [he] has an abnormally high subjective estimate of the probability of occurrence of the unfavorable outcome" (p. 315). As a result, "all situations … will generate a relatively high level of threat with its consequent anxiety." The compulsive behaviors are "regarded as the person's best attempt to reduce threats where no appropriate threat-reducing action can be taken" (p. 316). Carr acknowledges that "no account as yet been given for the origins of the observed high subjective estimates of the probability of unfavorable events" (p. 316). As noted earlier, he finds that the psychoanalytic explanation for these origins is unsupported by evidence. Therapeutic techniques such as "response prevention" for "motor compulsions" are useful, but do not regularly provide sustained benefit. Seketee et al. (1982), however, find that a combination of response prevention and in vivo exposure is highly effective (70–80 percent), with only 20 percent relapse on followup (mean, 11 months post-treatment). Like many behaviorists, they do not speculate on the etiology or the meaning of their patients' behaviors. Finally, Millar (1983), citing the observations of Beech and Vaughan (1978) that behavior therapy affords only short-term effects in obsessive-compulsive neurosis, advocates the addition of intense confrontive psychotherapy in order to deal with the high level of hostility toward others which is "often outside conscious awareness." (This recommendation is consistent with the increasing trend among behavior-oriented therapists to recognize unconscious affective determinants of behavior.)
Biological Factors

It is above all in the biological area that the most intensive activity can be found in the recent literature on obsessive-compulsive neurosis. This explosion of research has been stimulated by the finding that both in adults (Thoren et al., 1980; Insel et al., 1983) and in children (Flament et al., 1985) the tricyclic drug clomipramine, a chemical analogue of imipramine, is effective in reducing obsessive-compulsive symptoms. This fact has generated hypotheses and investigative efforts to determine possible neurochemical factors responsible for or associated with the disorder. Elkins et al. (1980) present a conception of a neurobiological foundation for the disorder, based on such factors as twin studies, association with Tourette's syndrome and other tic disorders, and neuropsychological test data, as well as response to clomipramine. Flament et al. (1987) conclude from their study of preadolescent and adolescent obsessive-compulsives, that clomipramine produces a significant lowering of platelet serotonin concentration, suggesting a specific role for serotonin in the biology of this disorder. This essentially confirms the findings of Thoren et al. in adults.

Baxter et al. (1987) describe improvement with other antidepressant drugs (trazodone, MAO inhibitors). Further, they report that PET scanning shows an increase in glucose metabolism in the left orbital gyrus and in both caudate nuclei; this pattern persists even after successful drug treatment. These authors emphasize that "our findings do not address the cause of obsessive-compulsive disorder but rather the neuroanatomic localization of the cerebral glucose metabolic processes that may mediate its expression" (p. 217). Marks et al. (1980) also find that clomipramine is effective, but only with patients who have an associated depressed mood. Like Thoren et al. (1980), they observed that patients tended to relapse when the drug was discontinued. At the same time, they found that exposure in vivo to feared situations led to lasting improvements in ritualistic behaviors, though it had no effect on mood. Clomipramine and exposure had additive effects, and tended to improve compliance with the behavioral treatment. Finally, Behar et al. (1984) found, on CT scans, a higher ventricle/brain ratio than in controls in a group of adolescents with obsessive-compulsive disorder. In addition, these patients showed deficits on spatial-perceptual tests and a greater frequency of "soft" neurological signs. These findings suggest, they say, right cerebral hemisphere dysfunction, and raise the possibility of a structural deficit in the brain. This suggestion might well be consistent with that of Smokler and Shevrin (1979) that persons with obsessive-compulsive cognitive style show a higher degree of left hemisphere activation than do those with hysterical style, who show a predominant right hemisphere activation, and, of course, with Freud's hypothesis about the precocity of ego development as compared with libidinal development in the pathogenesis of obsessional neurosis.

Obsessive-compulsive Disorder and Obsessive-compulsive Personality: The New Nomenclature

As noted earlier, it has been a commonplace of psychoanalytic thought on the subject that obsessive-compulsive disorder (or obsessive-compulsive neurosis) is developmentally and structurally allied to obsessive-compulsive personality. The emergence of the neurotic syndrome represents, in this view, a breakdown and regressive reintegration of the underlying personality structure. Recent reports, however, cast doubt on this supposed relation. Insel (1984a), for example, states explicitly that obsessive-compulsive disorder is not a severe form of obsessive-compulsive personality. Between 16 percent and 36 percent of patients with the
neurosis do not have premorbid obsessive traits. In fact, he states, obsessive-compulsive personality tends to decompensate not into the neurosis, but into depression. The premorbid personality of the patient with obsessive-compulsive disorder is likely to be "cautious and introverted" rather than showing the classical anal triad of orderliness, obstinacy, and parsimony. Flament and Rapoport (1984) concur with respect to children; they found that few if any of their patients were clean, orderly, or ruminative, nor did they manifest the classical "anal triad." Rather, they tended to be shy and nonaggressive. The obsessive-compulsive children showed no more "normal developmental rituals" than did controls, and on followup "there were more compulsive personality diagnoses than at baseline," suggesting that the latter might be a consequence of the neurotic disorder rather than a predisposing factor (Rapoport, personal communication).

This view is adumbrated by Weintraub (1981) who says, "Most compulsive characters do not develop neurotic symptoms and many compulsive neurotics do not have compulsive character traits" (p. 165). In their intensive study of 44 well-defined cases of obsessive-compulsive disorder, Rasmussen and Tsuang (1986) found that all had compulsive traits premorbidly. Nonetheless, they, too, concluded that "there is no direct relationship between the compulsive personality disorder and obsessive-compulsive disorder in general" (p. 325). They also found a high incidence of depressed mood (80 percent) and of diagnosable major depressive illness (30 percent) in their subjects.

Discussion

Although the designation of the obsessive-compulsive syndrome emerged from the French descriptive tradition, it was Freud who brought it out of the fog of 19th-century mysticism into the light of human experience. His constructions and those of his followers have made it possible for the observer to empathize with the torments of the obsessional, to lend content to his irresolute doubting, and to place his ritualization and rumination in a developmental and interpersonal context. They have enabled clinicians, researchers, and in many cases patients themselves to make sense of a baffling and often crippling disorder.

It must be acknowledged, however, that the therapeutic efficacy of the application of those constructions has been less than dramatic. Despite anecdotal reports of successful treatment of obsessive-compulsive neurosis, there is little hard evidence that analysis has been any more successful than other methods; indeed, in their review of 13 published followup studies, Goodwin, Guze, and Robins (1969) were unable to find evidence supporting the value of any specific therapy for this disorder. Insel (1984b) states, "In our series of 21 patients, who were collectively the recipients of more than one century of psychodynamic treatments, we had no reason to be ... optimistic... [Nowhere] in the literature on the psychodynamic treatment of obsessional states are there clear and consistent data documenting the frequency of positive responses to psychodynamic approaches" (p. 720). Were demonstrated therapeutic success a test of construct validity, psychoanalysis would not fare well with obsessive-compulsive neurosis.

The current state of knowledge testifies to the necessity of a broad perspective synthesizing knowledge brought from multiple sources. Recent discussions by analysts such as Reiser (1984), Cooper (1985) and Schwartz (1987) and neurobiological researchers such as Kandel (1983) and Winson (1985) coincide in their plea for the integration of psychoanalytic and neurobiological perspectives.
Behaviorists have been, perhaps, less outspoken in this regard, but Lazarus (1976) and others, as noted earlier, recognize the role of affective and interpersonal factors in their therapeutic methods.

The psychoanalytic picture of obsessive-compulsive neurosis is in my view profoundly convincing in its delineation of the conflictual struggle of a patient in the here-and-now of daily experience and observation. The ambivalence, the desperate need for control, the struggles against what the patient experiences as forbidden wishes, the rigid and implacable quality of the internal prohibitions, the propensity for magical thinking, the confusion between thought and action—all of these are live and experience-near data which few sensitive observers could question.

What is less certain is the issue of etiology and pathogenesis, and it is here that both neurobiological and behavioral constructions become heuristically helpful. We have, of course, long ago given up the id-psychological connection associated with toilet-training traumas; recent emphasis has more properly been given to ego-psychological considerations of control related to "strain" trauma and more pervasive patterns of child-parent interaction leading to the establishment of what Erikson (1950) calls the "sense of autonomy." But it was Freud, after all, who, rejecting Janet's notions about "degeneracy," still advanced the idea of "constitutional" predisposition to neurotic development, at least to choice of neurosis. It was he, too, who suggested that "precorcity" of ego development—that is, an imbalance between cognitive and affective development—might lie at the core of this disorder. Current concepts of hemispheric differentiation of function allow for the postulation, implicit in the work of Smokler and Shevrin (1979), in the "isolation of affect" and "intellectualization" of the obsessional and in the cognitive elaboration of his self-torturing thoughts, of a predominance of left hemisphere activity and/or a defect in right hemisphere structure or function, as suggested by Behar et al. Baxter's finding of increased metabolic activity on the left side of the brain in obsessive-compulsive patients would also be consistent with this hypothesis; indeed, that such activity persists after drug-induced amelioration of symptoms can be thought of as consistent with a stable, trait-related characterologically based disposition. And the demonstrated clinical efficacy of clomipramine lends strong support to the hypothesis of a neurochemical factor in either the genesis or the biodynamics of the disorder.

The questionable connection between obsessive-compulsive disorder and obsessive character, perceived as self-evident in most psychoanalytic writings, raises other issues. Recent studies of temperamental characteristics of children (Thomas and Chess, 1977); (Thomas et al., 1982) suggest that such traits as shyness, avoidant tendencies, and intolerance of change can be observed early in childhood. Although they have not been shown to be invariant and unchanging as development proceeds, their existence as characteristics so early in life strongly suggests a constitutional predisposition to certain personality traits, independent of the drive-defense or interpersonal conflicts that the psychoanalytic literature suggests are determining factors. The finding that a substantial proportion of patients with obsessive-compulsive disorder do not show the classical obsessional or "anal" character premorbidly, and the common clinical observation that obsessional characters typically develop depressive rather than obsessional-neurotic symptoms, leaves one to wonder whether the similarities between the neurosis and the character style reflect the limits of human reactive possibility, rather than a common etiology. At least, these recent findings raise serious questions about the conflictual origins of the obsessional character, whatever its relation to the obsessive-compulsive disorder.1(1For an elaborated statement of these questions and a novel hypothesis of the nature and biosocial genesis of personality disorders, see Cloninger (1987)).
Schwartz (1987) proposes an affect-based model for the integration of psychoanalytic and neurobiological concepts that incorporates aspects of learning theory as well. In his view, "parental non-verbal behavior and communication evoke in children the affects that guide character development and choice of defense, and ... these processes are consistent with an affect-reinforced associative learning model comprising both operant and classical conditioning paradigms" (p. 467). Schwartz sees psychoanalysis as "rely[ing] for its therapeutic effectiveness on extinctionlike processes in which a new experience in the analyst-patient relationship leads to the modulation or extinction of initially crippling signal affects" (p. 467). Such a formulation would readily account for, and be consistent with, learning theory models both of the acquisition of obsessive-compulsive (or other) symptoms and of therapeutic intervention; the technical differences between these and psychoanalytic methods are, in part at least, the function of divergent (i.e. "humanistic" and "scientistic") concepts of mind.

It is certainly premature, at this juncture, to speak of an integration—or even a rapprochement—among these varying viewpoints, with respect to obsessive-compulsive neurosis or anything else. Whether innate biophysiological dispositions induce (or favor) specific modes of learning and conflict management; or whether special kinds of infantile interactional experiences generate specific fantasy structures, unconscious anxiety situations, and modes of defense that tend to result in dyssymmetries of brain structure and function; or whether early classical and/or operant conditioning patterns generate, through faulty learning experiences, maladaptive modes of anxiety management that are favored by or themselves favor aberrant brain structure—any or all of these may be partially true.

What is apparent is that one-dimensional models can no longer be maintained, nor is it likely that unidisciplinary research efforts will carry us much farther. The psychoanalytic study of psychopathology, like that of development, must be responsive to new knowledge generated in other fields. Recent work by Stern (1985), Emde (1983), Demos and Kaplan (1986), and others have begun to point some of the directions in which such collaborative and integrative research must go. The poverty of the psychoanalytic literature on obsessive-compulsive neurosis in the past two decades gives clear testimony to the need for such interdisciplinary work, in which psychoanalysis can contribute its appropriate share to the growing quantum of knowledge. Insel (1984b) expresses skepticism about the role of repression and other unconscious defenses in this disorder. "During the placebo condition," he says, "obsessional patients gave responses that were remarkably laden with primitive instinctual content, much of which was described affectively and not repressed ... obsessional patients are frightened by their thoughts (which they cannot repress) and they only begin to talk about them when they are less fearful" (p. 720). This observation is consistent with Freud's (1926) statement that in obsessional patients the dominant defenses are not repression, but isolation of affect and undoing; indeed, these considerations led him to widen his conception of defense beyond that of repression. Psychoanalytic research will have to provide further substantial data to support its dynamic as well as its genetic hypotheses if the unique humanistic perspective of psychoanalysis on the individual is not to be replaced by a more scientistic focus on the generality.

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