Is There a Connection Between Object Relations (as described by Klein), Problems with Sexual Intimacy and Obsessive Compulsive Disorder?

Beverley Mears

Registration Number 1405992

A Thesis Submitted for the Degree of Professional Doctorate

Department of Psychosocial and Psychoanalytic Studies

University of Essex

Date of Resubmission for Examination 2nd October 2018

Dedication

I dedicate this work to my mother Margaret Garlinge, who died in 2017. She desperately wanted to see me complete this work, but sadly did not make it.

Is There a Connection Between Object Relations (as described by Klein), Problems with Sexual Intimacy and Obsessive Compulsive Disorder.

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ABBREVIATIONS

CASP	Critical Appraisal Skills Form
DSM	Diagnostic Statistical Manual of Mental Disorders published by The American Psychiatric Association
ICD	International Classification of Diseases and Public Related Health Problems maintained by the World Health Organisation
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorder
OCI	The Obsessive Compulsive Inventory (Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., & Amir, N., 1998)
PEPweb	Psychoanalytic Electronic Publishing Database
RIO	National Health Service data operating system
SS	Sexuality Scale (Snell & Papini, 1989)
WHO	World Health Organisation

Is There a Connection Between Object Relations (as described by Klein), Problems with Sexual Intimacy and Obsessive Compulsive Disorder.

Abstract

The purpose of this mixed method study carried out in an NHS mental health setting was to elucidate the connection between what was presented in the consulting room as OCD and how it is used to mask early object relations failure, which re-surfaces in adulthood as difficulties within the arena of sexual intimacy. The literature review identified the theoretical and empirical evidence for this hypothesis and highlighted gaps in the current understanding within psychoanalytic thought and object relations perspectives. The theoretical concepts used to understand the clinical data was based on Melanie Klein's Object Relations Theory. The textual analysis of structured interviews identified levels of obsessive compulsive symptoms and sexual perception categorized as sexual esteem, sexual depression and sexual pre-occupation. Qualitative data was collected from a single case study and provided contextual information including unconscious material. The results of the quantitative study provided evidence for the intensity of OCD and identified negative sexual esteem and negative preoccupation as the dominant features within the sample; whilst the single case-study found evidence that OCD rituals and ruminations were used to mask disruptions in object relations which were noticed in anxious sexual relations.

The conclusions of the study offer an important consideration for the treatment of OCD in an NHS setting. It adds to the psychoanalytic theory of obsessional neurosis in relation to the unconscious actions involved during sexual relations. Recommendations for further research include additional quantitative research with a larger sample and analysis of additional single case studies to provide additional

evidence of the concept.

Key Words: Obsessive Compulsive Disorder, Object, Object relations, Object Relationships, Projection, Sexual Intimacy, Symbol Formation.

Glossary of Terms

Obsessive Compulsive Disorder: An anxiety disorder characterised by recurrent, persistent obsessions or compulsions. Obsessions are the intrusive ideas, thoughts, or images that become the focus of the individual's distress. Compulsions are repetitive and seemingly purposeful behaviours, from which the individual does not derive pleasure, although it may provide a release from tension.

Object: The mental life of the child and adult consists of a complex system of phantasied relations between self and other, known as objects. These inhabit the external word and are part of the imaginary world of internal objects. Klein's sees objects as inherent in and created out of drives themselves, independent of real others in the external world. Klein suggests that perceptions of real others are merely a scaffolding of projections of the child's innate object image. (Greenberg and Mitchell 1983, p. 130)

Object Relations: A term from psychoanalysis beginning with Freud that gave rise to an aspect of psychoanalytic theory. The Object Relations School includes a number of different theoretical points of view, and generally indicates a focus on the state and character of objects. Klein described an experience of objects and the psychological content of the anxieties about them. (Hinshelwood 2013) Object relations involve a theoretical framework using internal objects and how they are then relived in actual relationships.

Object Relationships: Klein and her contemporaries describe how the desire for relationship with an other is present from the very beginning of life. The knowledge of a possible connection stimulates interest and desire. Bion (1962b) describes the emotional links between objects, which he formulated as being 'L' (loving), 'H' (hating), or 'K' (the wish to know the other). Object relationships are where internal object relations are enacted and noticed.

Projection: The term projection is used in a number of meanings; however for the purpose of this study, projection is used in the Kleinian sense. Hinshelwood (2013 p. 397) outlines the ways in which Klein used the term. These included:

1) Projection of the internal object: Noticed when an infant experiences the absence of mother as an active soothing presence and instead is experienced as a bad object causing hunger pains. This bad object is expelled out into the external world through the experience crying and is then less terrifying.

2) Projection of the death instinct: Hinshelwood (2013 p. 398) describes this a '*Klein's view of the death instinct projected (or deflected) outwards means that there is a primary inwardly directed aggression which turns outward against some outside object*'.
3) Externalisation of conflict: Noticed through observation of the child playing with toys where the internal conflict or internal relationship is projected into the external world through the object of the toy.
4) Projective identification: Part of the self that is attributed to an object. Klein saw this as a function of the ego, whereby unwanted bad feelings are seen in an other and completely disowned.

Sexual Intimacy: Includes a broad range of sensuous expression with an other. Intimacy involves an unmasking of the self in order to be vulnerable in a trusting, loving relationship. This shared sexuality ultimately results in loving sexual intercourse described in psychoanalytic literature as coitus.

Symbol Formation: The term 'symbol formation' is used in psychoanalysis to describe a representation of a significant idea, conflict or wish. The ability to move on from relating concretely to archaic objects to relating symbolically to substitute objects (symbols) is both a developmental achievement and a move made because of the anxieties involved in relating to primal objects. Segal further developed Klein's theory of symbols, distinguishing between the symbol proper formed in the depressive position and a more primitive version, the symbolic equation, belonging to paranoid

schizoid functioning. In the symbolic equation, the symbol is equated with the thing symbolized (Melanie Klein Trust).

Chapter 1 Introduction to the Study

1.1 Introduction

Freud (1926 p. 113) described obsessional neurosis as "*unquestionably the most interesting and rewarding subject of analytic research*," he also recognised that it had "*not been mastered*".

In the last thirty years other psychological models have forged ahead with their understanding and treatment of the disorder whilst psychoanalysis has found itself relegated to the background, certainly in terms of treatment for patients diagnosed with obsessive compulsive disorder (OCD) within the NHS. Since Freud wrote about obsessional neurosis (1909) in the case of the Rat Man; psychoanalysis has learnt little more on the subject. His daughter, Anna Freud, acknowledged this when she presented a psychoanalytic overview of Obsessional Neurosis to Congress in 1966. She criticised the scarcity of original findings, and characterised the main bulk of publications after Freud "*as merely amplifying and corroborating*." This theme continued to be written about by others (Nagera, 1976; Esman, 1988; Brandchaft, 2001, 2007; Bristol, 2001). Brandchaft (2007, p. 671) wrote:

> "*Freud's acknowledgment of his failure (Freud, 1923/1961a) and the failure of succeeding psychoanalysts (Esman, 1988; Freud, 1966), in this most pervasive and disabling of psychological disorders, contributed importantly to the protracted and ongoing "crisis in psychoanalysis" and fuelled a decisive shift in the direction of pharmacological attempts to treat this and other psychological disorders".*

Chapter 1 Introduction

1.2 Motivation for the Research Study

During my work as a Senior Psychoanalytic Psychotherapist working with patients with a diagnosis of Obsessive Compulsive Disorder, I noticed that OCD appears to mask significant difficulties in interpersonal relations, which are often played out within the arena of sexual intimacy. I knew that psychoanalytic psychotherapy would have an appropriate method for treating these patients, despite the guidance that Cognitive Behaviours Therapy (CBT) should be the method of treatment.

Discussions with Clinical Psychology colleagues highlight treatment protocols for CBT fail to take into account wider issues, whilst the exploration of sexual intimacy is commonly avoided in discussion with patients, as it does not form part of CBT treatment protocols. This is in contrast to psychoanalysis, whose interest lies in exploring the impact of early object relations and the influence of the unconscious on present day relating. Exploration of Klein's Object Relations Theory helped to make sense of what was being noticed in the consulting room. In discussion with my clinical supervisor, I developed a working hypothesis to help me contextualise the phenomena. This is that Klein's account of obsessional neurosis, as resulting from projections of disowned and hated figures into others, who are then experienced as hating and persecuting figures and have to be warded off with obsessional rituals, is relevant to understanding the sexual problems of OCD patients.

1.3 Definition of Obsessive Compulsive Disorder

A diagnosis of Obsessive Compulsive Disorder (OCD) is informed by The International Classification of Diseases-10 *Classification of Mental Behavioural Disorders* (ICD-10, 1992) or the Diagnostic and Statistical Manual of Mental Disorders V (American Psychiatric Association, 2013). In the UK, the revised ICD-10 is most commonly referred to and lists OCD in its own subcategory (F42 p142) under the category of Neurotic, Stress-related and Somatoform Disorders (F40-F48). OCD is described as an anxiety disorder characterised by recurrent, persistent obsessions or compulsions. Obsessions are the intrusive ideas, thoughts, or images that become the focus of the individual's distress. Compulsions are repetitive and seemingly purposeful behaviours, from which the individual does not derive pleasure, although it may provide a release from tension.

Once a diagnosis has been established, consideration is given to treatment. Often treatment involves pharmacological interventions alongside Cognitive Behavioural Therapy (CBT). This is in line with recommendations put forward by the NICE Guidelines for OCD (2005). NICE is an executive non-departmental public body of the Department of Health in the United Kingdom, serving the NHS in England and Wales. The updated guidance for OCD, NICE CG 31 (September 2013) is based on 16 RCT's chosen from 1909 studies, which were gathered during literature searches between 30th October 2003 and 2nd April 2013. From these studies key points were identified and included in the revised guidance. These guidelines recommend that adults with a moderate functional impairment should be offered either a course of selective serotonin reuptake inhibitor (SSRI) or more intensive

individual or group CBT or family CBT based interventions (for children and adolescents).

1.4 Setting for the Research

1.4.1 Demographic Profile of Sample Population.

This study took place in a NHS Secondary Care Psychological Therapy Service. The Trust serves a local population of approximately 250,000. The area has a relatively diverse level of deprivation, with three wards falling within the 20 per cent most deprived in England, and two within the 20 per cent least deprived. It has less ethnically diverse communities than the England average. The Secondary Care Psychological Therapy Service (SCPTS) is part of the Community Mental Health Team, providing a core service to meet the mental health needs of people of working age (eighteen years – 65 years) and adults with acute, serious and enduring mental health problems in the area.

1.4.2 Operational Definition of Study Population

The study population was made up adults between the ages of eighteen years to 64 years, who were registered as patients with the Community Mental Health Team and who have either been diagnosed with Obsessive Compulsive Disorder or presented with obsessive-compulsive ruminations.

1.5 Treatment of OCD in the NHS

Treatment of choice in the NHS is informed by The National Institute for Health and Care Excellence (NICE). From reading the NICE guidelines for OCD, psychoanalytic interventions are not recommended. It is worthy of note that NICE recommend family interventions as this suggests that there is sufficient evidence that family interventions improve the symptoms in some way.

In todays culture of evidenced-based treatments and Randomised Control Trials (RCT's), psychoanalytic psychotherapy is often 'confined to the edge', whilst CBT is recognised by many as the most fitting treatment option because of the RCT evidence they provide. Despite this widely held belief, psychoanalytic psychotherapy has much to offer patients presenting with severe symptoms of OCD. Object Relations Theory describes the optimal conditions for the development of a healthy sense of self, and identifies significant points where, if these conditions are not met, an obsessional neurosis can develop. This study will go on to argue that problems with sexual intimacy arise out of anxiety related to the object located in Klein's (1932) paranoid schizoid position.

1.6 A Theoretical Construct

1.6.1 Introduction

The theoretical background for the research will be considered using Klein's Object Relations Theory along with her understanding the development of

obsessional neurosis, the term used in psychoanalysis to describe Obsessive Compulsive Disorder.

1.6.2 Klein's Object Relations Theory

Klein developed her understanding of object relations by describing her child patient's experience of his objects and the psychological content of them. Through the observation of the child at play and in enacted dramas with her child patient, Klein noticed that the child had feelings for his objects, who appeared to be real, living and feeling. This was in conflict with Freud's concept of instinct. Hinshelwood (2013 p. 372) reports that Klein was able to keep both the concept of 'object' and ' instinct' when she noticed that the relations with the object were exactly defined by the impulse from libidinal sources. Klein discovered that the child believed that the objects intentions mirrored the child's own particular libidinal impulses active at that time.

1.6.3 Paranoid Schizoid Position

Klein's Paranoid Schizoid position, which Klein (1932) considered to be in the earliest months of life involving a constellation of anxieties, defences and internal and external object relations. This involves a great deal of anxiety triggered by the death anxiety as a result of the trauma of birth and by feelings of hunger and frustration. The main characteristic of the paranoid-schizoid position is the splitting of both self and object into good and bad that are then projected out separately into parts of the mother. The result is that mother is split in to good object or breast that feeds and

nourishes and bad object or breast that denies nourishment and frustrates. The 'good' and the 'bad' objects are then introjected and a cycle of projection and introjection ensues. Klein highlighted the importance of omnipotence and idealisation in this process as bad experiences are omnipotently denied and good experiences are idealised and exaggerated as a protection against the fear of the persecuting breast. The main defences involved at this stage are the phantasies of splitting, projection and introjection. Klein (1932) describes splitting of good and bad object as essential for healthy development in order to provide a basis from which to begin to integrate good and bad aspects of the self. Klein warns us that where fragmentation, another more severe form of splitting, persistently occurs, the ego is weakened and can result in a severe disturbance.

The analysis of the clinical data in this study involved identifying evidence of splitting, projection and introjection in order to confirm the operation of the paranoid schizoid position.

1.7 Study Aim and Research Questions

1.7.1 Aim

The aim of this study is to explore the connection between object relations, problems with sexual intimacy and Obsessive Compulsive Disorder. This comes from noticing in the treatment of OCD patients that there appears to be a splitting of objects that involves an exchanging of good and bad object positions between the original object relation with mother and the sexual partner. This observation can be understood psychoanalytically as follows: in obsessional neurosis,

the good object is preserved by splitting and investing the bad object in the sexual partner who, in sexual relations, restores the good object by becoming the good object for internalisation. In this way, the good mother is restored, the sexual partner returns to the bad object position, and the cycle repeats itself. OCD rituals then form part of the manic reparation process, restoring the good object position, and at the same time, silencing unconscious aggressive impulses directed towards the object.

1.7.2 Research Question

The questions designed to answer the working hypothesis were:

1. What is the connection between object relations, problems with sexual intimacy and Obsessive Compulsive Disorder?
    i) What is the nature of the sexual difficulty, as categorised in the quantitative study?
    ii) Is there a correlation between the Sexuality Scale and Obsessive-Compulsive Inventory Questionnaire results?
    iii) Are sexual difficulties identified in the findings of the quantitative study explained in the findings of the qualitative study?
    iv) How does the patient in the single case study speak about her object relationships and what is the connection to OCD?

2. What are the implications for the treatment of OCD in the NHS?

Chapter 2 Literature Review

2.1 Introduction

This chapter describes the method, results and conclusions of a review of the literature carried out to explore existing research into Obsessive Compulsive Disorder, Object Relations defined by Klein and sexual difficulties. The literature search included quantitative research and meta synthesis studies as well as expert papers.

2.2 Aims

The aim of the systematic literature review was to identify relevant studies, psychoanalytic papers and other expert papers by using the words **OCD AND Sexual Intimacy AND Object Relations** to gather research relevant to the psychoanalytic concept of obsessional neurosis. Initially searches gathered a small number of results and so it became necessary to broaden the search from qualitative to quantitative research in order to fully investigate research in the field. Preliminary searches of Social Science databases limited to OCD, Sexual Intimacy and Object Relations gave limited results. This is because terms used in psychoanalysis are not easily transferable to other disciplines. The database that gave a number of papers relevant to the psychoanalytic concept of Obsessional Neurosis and Object Relations was PEPweb (Psychoanalytic Electronic Publishing). Broadening the search to social science databases provided quantitative and mixed method studies that were of interest to the current study. This meant that other terms had to be used. The terms '**object relations'** and '**obsessional neurosis**' were converted to '**relationships**' and '**obsessive compulsive disorder**'. The term '**sexual intimacy**' and '**sex**' were used to

glean as many results as possible. The results were then systematically reviewed to identify significant studies to my research.

2.3 The Benefits and Limitations of a Systematic Literature Review

Systematic reviews are described as a rigorous and transparent form of literature review (Mallett 2012). They were first used in medical sciences in the 1970s to examine the effectiveness of health-care interventions and since that time have been used across a wide range of disciplinary fields. Petrosino *et al.* (cited in van der Knaap *et al*. 2008, p. 48) describe systematic reviews as:

> 'The most reliable and comprehensive statement about what works'.

Mallet et al (2012) report that systematic reviews involve identifying, synthesising and assessing all available evidence, quantitative and/or qualitative, in order to generate a robust, empirically derived answer to a focused research question. The first step in a systematic literature review is to deconstruct the research question by identifying the research population, the intervention and the outcome, which then provide the search strings to be used in the literature search. A drafted study protocol describes definitions, search strings, search strategy, inclusion and exclusion criteria and approach to synthesis. Mallett et al (2012) report that this protocol is often peer-reviewed and piloted. This may lead to a revision of the search strategy. Next the systematic search is conducted using academic databases and institutional websites. Initially all studies found are included and then screened on relevance of title, abstract and full text, by using the pre-defined inclusion and exclusion criteria. Once screening has been completed, the studies included in the final analysis are categorised by

intervention, study quality, outcomes, research design and type of analysis. Finally the extraction of relevant quantitative and/or qualitative data is collected in order to synthesise the evidence. A meta-analysis is then used to combine and compare quantitative results.

A challenge for a systematic literature review involves the method used for searching; academic journals can provide a limited number of results that meet the search criteria, whilst institutional websites can provide a higher number of results but can undermine the objectivity of the search and retrieval process and introduce bias to the review process (Mallett 2012). A further challenge is that inconsistent screening can occur, particularly when there are time constraints. Bryman (2016) highlights a limitation of systematic literature reviews in social scientific fields, as they are often characterised by low consensus concerning key research questions because of different theoretical approaches. This was a problem that occurred in the systematic review carried out in this study, which will be discussed below.

2.4 Method

2.4.1 Search Strategy

The literature search began in the autumn of 2014. The search involved using an Open Athens account to access PsychINFO, Medline, PubMed, CINAHL and PEPweb. References found in papers were also searched using Google Scholar. In addition an online search was conducted of papers in peer reviewed journals and books published between 1998-2014. The search title terms included **Psychoanalysis, Psychotherapy** & **Psychiatry**. The search terms were **Obsessional Neurosis,**

Obsessive Compulsive Disorder, Object Relations, Relationships, Sex & Sexual Intimacy. Reference lists and citations were searched to identify other suitable studies.

Searches were repeated again between 2015-2017. An alert was set with Karnac Books online catalogue in order to keep up to date with recent publications.

2.4.2 Search Process and Identifying Relevant Literature

Databases were searched and exclusions were made after searching titles and reading abstracts. At each stage papers were rejected if they did not meet the criteria for this study. The total number of papers excluded was 197.

A search of PEPweb produced 74 results. The sifting of PEPweb results produced 31 papers, which contained at least two of the search criteria. The total number of papers reviewed in the complete process was 271. This included papers consulted for the theoretical framework and those required to understand more about the presentation of the patient in the case study.

2.4.3 Quality Appraisal

The CASP (2013) Systematic Review Checklist was used to assess the quality of the gathered literature for the quantitative studies and expert papers. Results can be found in Appendix J. The Meta Synthesis papers were assessed using the Cerqual Tool (2016).

The reporting of results is broken down into the following categories: quantitative, qualitative, Meta synthesis and expert papers. The papers in each category will now be discussed using the characteristics, methods and data analysis.

2.5 Results

2.5.1 Quantitative Studies

2.5.2 Character

There were 12 papers in this category; 8 originated from America, 2 from New Zealand, 1 from Turkey and 1 from England. The participants included children between the ages of 8yrs-17yrs; university undergraduates and patients diagnosed with an anxiety disorder or OCD and reported some form of sexual difficulty or dysfunction. One study (Faisander, Taylor, & Salisbury, 2012) used an online survey method. The number of participants ranged from 20-383. Studies involved men and women in the sample population.

2.5.3 Method

All of the studies in this category used questionnaires. One study, a doctoral thesis (Fons 2008) used a rage of questionnaires including Derogatis (1997) Interview for Sexual Functioning (DISF), Quality of Life Inventory (QOLI, Frish 1994), Severity of Anxiety Symptoms (SAS, Zung 1971), Depression Anxiety Stress Scales-21 Items (DASS -21; Lovibond & Lovibond 1995), Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gersky & McNally, 1986) and the Patient Health Questionnaire

(PHQ9 Kroenke, Spitzer & Williams 2001). Other studies (Staebler, & Pollard, (1993) and Aksoy, et al., (2012)) used only 2 questionnaires.

Out of the 12 studies, 4 were assessing OCD and sexual problems (Rasmussen & Tsuang (1986), Staebler & Pollard (1993), Fernández de la Cruz (2013) and Aksoy et al., (2012). Four studies Sbrocco et al. (1993), Van Minnen (2000), Figueira (2001) and Fons (2008) investigated the correlation between a range of anxiety disorders and sexual problems and 4 studies; Creedon (2004), Faisander (2012), Wetterneck (2012) and Haciomeroglu (2014) explored the relationship between attachment and sexual problems or behaviours.

In the scoring on the CASP table (Appendix J) a number scored as strong studies, including Van Minnen (2000), Fernández de la Cruz et al., (2013) and Faisander et al., (2012).

2.5.4 Analysis

All of the findings from the quantitative studies found a connection between OCD and sexual difficulties.

Aksoy, U. M. et al (2012) discovered from their sample that childhood behaviour problems were significantly more common in personality disorder and OCD patients than their control group of 40 healthy volunteers. Sexual dysfunction unrelated to prescribed medication was found to occur in patients with a diagnosis of OCD or personality disorder. Female patients with OCD experienced sexual problems, not only in the desire phase but also arousal and orgasm phase. The

evidence of sexual dysfunction unrelated to medication adds value to the hypothesis of the current study. Aksoy et al. (2012) found in contrast with results reported by Sbrocco et al. (1993), but similar to findings by Figueira & Possidente (2001), that male OCD and personality disorder patients had an increased rate of erectile dysfunction or premature ejaculation. Additionally in the OCD group there was a higher frequency of dysfunction in the sexual arousal and orgasm phase.

Fernández de la Cruz, et al. (2013) whose study involved 388 patients demonstrated that 25% of patients within an age range of eight to seventeen years had sexual obsessions; they had slightly more severe OCD symptoms and were more depressed than those without sexual obsessions. Aggressive and religious obsessions, magical thinking, fear of saying certain things, repeating rituals, superstitious games, mental rituals, and the need to tell, ask, or confess, were more frequent in participants with sexual obsessions.

Fons (2008) explored the relationship between sexual functioning and quality of life in anxiety disorder patients. Data from 64 patients was used for the study with a sample of 38 women (59.4%) and 26 men (40.6%). Of this 14.1% had a diagnosis of OCD. Whilst his study encompassed a broad range of anxiety disorders and therefore was limited in what it could offer specifically to our understanding of OCD and intimacy; he began with a hypothesis that those with more severe anxiety would demonstrate lower sexual functioning. This was not supported by the findings of the study. However, sexual desire and relationship functioning was found to be correlated with stress levels. He cites a number of authors who offer contrasting data around the

association between OCD and sexual dysfunction including Rasmussen and Tsuang (1986) who found that 30% of individuals with OCD reported loss of libido since the onset of the disorder. Van Minnen and Kampman (2000) found that females with OCD reported less sexual contact and lower desire than individuals without OCD. He also highlights that in comparison with 17.6% of the controls, 76.4% of OCD patients reported one or more sexual dysfunctions.

The studies that focused on relationship functioning and sexual desire found a connection. Fons (2008) found a correlation between sexual desire and relationship functioning with stress levels. He also highlights that in comparison with 17.6% of the controls, 76.4% of OCD patients reported one or more sexual dysfunctions. Rasmussen and Tsuang (1986) found that 30% of individuals with OCD reported loss of libido since the onset of the disorder. Van Minnen and Kampman (2000) found that females with OCD reported less sexual contact and lower desire than individuals without OCD. They report that in comparison with 17.6% of the controls, 76.4% of OCD patients reported one or more sexual dysfunctions.

Faisander et al., (2012) found that their study population reported higher fearful, dismissing, preoccupied, anxious and avoidant attachments and lower secure attachment than the non OCSB group. A correlational analysis further supported the relationship between OCSB and adult attachment. Creedon (2004, p.235) reported that:

"Successful mastering these skill domains is an important prerequisite for developing responsible sexual behavior as an adult, and that disruption to such skill development can lead to problematic sexual behaviour".

2.5.5 Meta Synthesis

2.5.5.1 Characteristics

There were 4 papers in this category. Two studies originated from the USA, 1 study originated from England and 1 large international study. Three studies involved the bringing together of studies, examining them and developing a new understanding; 1 study involved a follow up 25yrs after the initial treatment of psychoanalysis.

2.5.5.2 Method

Lefer (1997) describes the link between object relations theories and sexual development by highlighting the quality of connection between the mother infant dyad, which is internalised and becomes part of the self over time. He highlights that when attunement is not available, the child's later sexual development creates a sexualisation of earlier, painful, object relations. He describes *s*exuality as:

"*A psychosomatic experience that is a trajectory through time from earliest experiences of intimacy and security to adult maturity and bodily functions. Sexuality is not just physiology: cognitively, a personal meaning is involved*". (1997 p.18)

Nolan (2008) sought to elucidate the etiology and adult manifestation of OCD. He bases his paper on the work of Winnicott (1949/2004) whose concept of overactive mental functioning highlights the vital role played by a mother who is reliable and well functioning. Nolan connects anxious mothers to anxious babies and to future anxious adults. He suggests that anxious infants who go on to develop OCD do not learn to self-soothe their anxiety through relationships.

> "*In such cases there is no healthy maturation of the central nervous system, and the adult manifestation of OCD is, in fact, an attempt to move to such healthy maturation*". (2008 p.2)

A 25-year follow up study by Tyson (2009) describes a severely disturbed child treated with a three-year psychoanalysis at The Anna Freud Centre, beginning when he was seven years old. Difficulties in the mother infant relationship were reported, due to the mother suffering from severe postpartum depression that had a negative impact on her care giving. At 21 months his baby sister was born and he began to suffer from nightmares, temper tantrums, inconsolable crying, phobias and obsessive ruminations.

An international study by Radua, et al. (2014) analysed 34 studies and found that researchers in the field of neuroscience believe that the OCD individual gets stuck in repetitive thought and behaviour cycles due to the imbalance within these pathways, which are involved in initiation and termination behaviour. This view argues that the biological factor is significant. Furthermore, research into brain

development has shown that the infant's contacts with caregivers, indelibly influences the evolution of brain structures responsible for the individual's social interactions.

2.5.5.3 Analysis

Lefer (1997) discovered that intimacy is only possible where negative projective identifications are at a minimum and the schizoid splitting of the other is not present. He warns that when this is not possible, sexual relations are used to compensate for low self-esteem, guilt and anger or to momentarily ease depression and sexual identity. He also warns that narcissistic injuries can become sexualised and sexual perversions can result. He reports on the importance of taking an accurate sexual history structured within an object relations theoretical construct at assessment. He describes his observation that the OCD patient's object relations center on winning or losing along with power struggles and strict standards. Sexual performance must meet those same exacting standards. Intimacy is avoided by objectifying the other and raising self-esteem through sexual prowess that requires power over the other.

Nolan (2008) identified a three-stage process to OCD beginning in infancy. The first stage is evident when the infant is forced into over active mental functioning when danger is perceived internally, in order to self-soothe. The second stage is when danger is perceived to be coming from outside of the family unit rather than from within. Obsessive thinking imagines that something terrible might happen to mother, and so a ritual is developed to self-soothe and overcome the anxiety. Nolan's third stage describes how when the child perceives himself to be in danger, thoughts

become extreme and inconsistent, although the individual realises that the obsessions are not rational.

In describing the etiology of OCD he points to lack of object constancy and the disruption in the relational interchange between mother and infant. Nolan describes how the infant attempts to do by mental activity what the environment is failing to do through physical or emotional soothing. This exaggerated mental functioning later becomes what is known as the all-consuming OCD behaviours.

Tyson (2009) reported the findings of the follow up of the patient 25 years later at the age of 32 when he described an unsatisfactory sex life with his partner and reported that what gave him most pleasure was "*reading sexual smut on the internet*" (2009 p. 926). The psychiatrist interviewing him felt that he met the sub-threshold symptoms of obsessive compulsive, paranoid, schizoid and schizotypal disorders. Furthermore, obsessive and depressive traits hid a more serious pathology with a risk of breakdown.

Radua, et al. (2014) found that there is a higher rate of OCD among first-degree relatives of adults with the disorder which points to a relationship correlation or genetic component. Physical or sexual abuse or other traumatic events are also associated with a risk of developing OCD as such events lead to high levels of anxiety where the trauma has not been fully processed and resolved.

2.5.6 Expert Papers

2.5.6.1 Characteristics

This category included the psychoanalytic papers from the PEPweb search, papers from the other database searches and 1 book containing a collection of papers. All took the form of case studies, which were used to develop theoretical understanding of OCD and the sexual problems of the patient. The studies originated from Austria (1), Italy (1) and USA (5).

2.5.6.2 Method

All expert papers were reviewed using the Cerqual Tool (2016), which appraised the methodological limitations, relevance, coherence and adequacy of the paper. The papers identified fell within 2 categories; case studies and the development of Freud's theory of obsessional neurosis.

Freud's paper the Rat Man (1909) describes how the Rat Man developed obsessional rituals to make reparation for the loving and aggressive impulses directed towards loved ones. Freud (1909) found evidence for his theory that the accompanying phantasies and symbolic meaning of the obsessive ruminations originated in sexual experiences of childhood.

Authors seeking to build upon Freud's concept of obsessional neurosis included Nagera, (1976); Esman, (1989); Brandchaft, (2001, 2007) and Bristol

(2001). Bristol (2001) was interested in exploring the history of childhood neurosis and its relation to the adult superego. He begins from the position that the concept of obsessional neurosis has its origin within the Oedipal conflict and superego formation. Brandchaft (2001) re-examines principal contributions made to the understanding of obsessional neurosis since Freud in an attempt to understand the failure of psychoanalysis to favorably influence treatment options. In his 2007 paper Brandchaft focuses on a spectrum of disorders, including OCD as he considers the influence of trauma early in life and impact upon formation of the personality.

Bristol (2001, p.286) considers OCD in light of Freud's (1926, 1930) writings on self-object tension and fears of object loss.

McGehee (2005) describes the analysis of a ten-year old boy, Evan, who first developed anxiety symptoms when he was approximately three years old. The parents reported details that suggested Evan struggled with Oedipal wishes, conflicts and high levels of anxiety. In this detailed case study, McGehee describes how many of the actions of the child were sexualised, often when he triumphed over the analyst in the game that they were playing:

> *"Often, we played games such as chess; when he won, he typically became extremely excited and would sing a song he called "The Skunk Song." This involved singing about how I smelled like one of his farts. At other times, he called me a woman. Or, in his excitement, he would bump into me in a way that was both hostile and sexualized. At other times he made body movements that*

seemed to be masturbatory and then got up and went to the bathroom". (2005, p. 223)

McGehee noticed that drawing attention to his sexual excitement, or the excitement at winning a game with his rival, immediately triggered an immediate regressive defence in response to anxiety. Gradually, Evan was able to understand that sexual excitement, or excitement at winning, led him to fear the analyst becoming upset with him. At other times it was evident that Evan was acting from a sadistic position by attacking the chess piece of the analyst and then mocking him.

Bisogni (2017) focused on describing his patient's obsessive compulsive defence organisations. Among the eleven case studies in his book are children, adolescents and one adult. In a case involving a teenage boy, Bisogni describes how his adoptive father had involved him in a subtly sexualised and vulgar alliance. Bisogni (2017, p.102) suggests that the father was a prototype of the phallic, eroticised, delinquent man. When his parents divorced, the child slept in his adoptive mother's bed, which was considered to be completely normal. He was referred for psychoanalysis after a psychotic breakdown, which was linked to a number of issues. These included: anxiety related to sexual arousal and sharing his mother's bed; the failure of resolution of the Oedipal situation and other latency issues; violent fantasies which could only be expressed and kept under control through obsessional formations; and the sense of being imprisoned by the parental couple which left him feeling that he would never be able to get away from them. During psychoanalysis he

realised that he was also held captive by his obsessional symptoms. As a result, he developed a masochistic response and began to cut and made numerous suicide attempts. Bisogni (2017) reports that the adolescent was constantly on the edge of being self-destructive and revealed all major changes in his life through some form of self- harm.

In a troubling case of an adult male suffering from encopresis and HIV, Bisogni (2017, p.170-184) provides clinical data from a session where the patient describes his sexual promiscuity, which seems to be connected to obsessional control. The patient had been having unsafe promiscuous sex since the age of thirteen years and had on occasions prostituted himself. His sexual practice was linked to a projected identification with his mother and her various sexual partners. He initially developed OCD during childhood, which seemed to have originated from his mother's ritualistic cleaning, and her demand that his tidiness matched her own. By the age of seven years he was able to clean his room to perfection. Throughout childhood he secretly soiled his pants and the ritualised washing that followed developed into a game involving his faeces. After puberty he developed rituals related to his sperm, which involved masturbating in the bath and watching it float in the water, then letting it dry on his skin. Alternatively he would let some of the sperm dry on his skin after masturbating in bed. Both of these activities excited him. He bathed once a week and this involved him using lotions on his body in a ritualised manner. As an adult, his sexual perversions were homosexual sadomasochistic sexual behaviours carried out at invitation only private clubs. During the analysis Bisogni (2017) identified two narrative themes around the development of his obsessions. The

first was his experience of childhood and puberty, and the second was a sexual compulsion of playing with death.

2.5.6.3 Analysis

Bristol (2001) concluded that he found differences in ego development and superego structures as described by Freud. Unlike Freud, who reported that ego defences and superego structures arise under the influence of instinctual life, Bristol found in his case study that ego defences and superego structures were grounded within object relationships and the resulting fantasies came from lived experience with others. He also reported that 'the central and essential life story of the male obsessional neurosis is the Oedipus complex and its superego' (2001, p.305).

The focus of the study makes it an important contributor to the current study as it points to the central role of the Oedipus complex and superego. A limitation is that it does consider any connection to adult sexual relations.

Brandchaft (2001, 2007) focuses on the treatment of anxiety disorders. In his 2001 paper he examines the treatment of obsessional neurosis in psychoanalysis and highlights the juxtaposition with CBT. Brandchaft (2007) describes the profound obstruction in the development of the personality, especially to self-differentiation and authenticity, which affect the quality of life as a result of disruptions in object relations. He reports that:

> "When the child is required preemptively to adhere to an inflexible personality organisation that caregivers bring to its needs for psychological distinctness, these earliest attachments exclude or marginalize spontaneous experience and second thought metacognitive processes of self-reflection. The child's ability to process new information and, accordingly, to self-correct and grow are impaired as its emerging sense of self is usurped. By repetitive process, the child's first reality becomes patterned into a set of immutable belief systems. These subsequently find their place in retrograde social systems in which authoritative first truths remain absolute". (2007, p. 668)

Whilst this paper is not specifically about obsessional neurosis it is of value to the current study as it clearly identifies the conditions where obsessional neurosis develops and the impact upon adult functioning.

McGehee (2005) reported that by the end of treatment he was able to understand more about how Evan's struggle with his feelings of anger led to his use of projection, and to fears of retaliation expressed in various forms of castration anxiety and other symptoms. The treatment was a success as it was able to uncover the origins of his anxiety and obsessional neurosis, Evan disclosed that the thing he had been most frightened of was of being too close to his mother and that she might take him over. This account of a case study provides rich clinical data that aids the understanding of the condition and the challenges facing someone with an obsessional neurosis.

McGehee was able to plot out the development of the obsessional neurosis; the struggles with Oedipal wishes were identified, as were the sexualised actions. A point of significance for this study was Evan's disclosure at the end of his analysis relating to the intrusive relationship with mother.

Bisogni (2017) discovered that as a result of being held captive by his obsessional symptoms, his child patient developed a masochistic response and began to cut, made numerous suicide attempts and was constantly on the edge of being self-destructive. All major changes in his life were marked through some form of self-harming behaviour.

The case studies reported by Bisogni (2017) are relevant to the hypothesis of this study as they both describe a connection between obsessional neurosis, intrusive object relations and intense anxiety related to sexual arousal or sexual behaviours. The first case study documents an inability to cope with developmental changes as a result of over sexualisation initially by his adoptive father and an unresolved Oedipal situation that could only be controlled through obsessive ruminations and managed through self-harming behaviours. Significantly anxiety related to developmental life changes were also noticed by acts of self-harm or suicide attempts, suggesting a desire to kill off the maturing, perhaps sexually maturing body. The second case describes how sexual promiscuity was used as a particularly destructive form of self-harm from early adolescents and documents an inability to develop a healthy object relationship. What both cases have in common is that both had an experience of intrusive parental

sexualisation, which significantly impeded the development of a healthy sexual self. Of importance to this study is that Freud's understanding that an obsessional neurosis is rooted in the anal sadistic phase can be noticed in the clinical material of these two cases.

Bisagni's experience of working in the NHS means that his work is an important contributor to this study. He reports that:

> "*Psychoanalytic psychotherapy is an effective treatment to help people suffering from OCD. It offers a space in which it is possible to gain an understanding of unknown and haunting content that produces such thoughts*". (2017, p. xx)
>
> ".

The eleven OCD case studies outlined in his book 'Obsessions: The Twisted Cruelty' confirm the thought that provokes OCD is deeply unconscious and remains hidden. As a trained psychiatrist and psychoanalyst, Bisagni is able to appreciate the challenges faced by the NHS, particularly the challenge of time in today's pressurized, solution-focused NHS. He reminds us that mental health does not know the variable of time and that the mind needs time to know the truth about itself (Bisagni, 2017, p. xxi).

2.6 Conclusion of the Literature Review

The aim of the literature review was to identify research studies and expert

papers of psychoanalytic writing about OCD, object relations and sexual intimacy. The review demonstrated that psychoanalytic concepts are not easily transferrable to other disciplines and so the search terms had to be widened to include generic terms. The terms obsessional neurosis and object relations could only to be found in expert papers describing theoretical and clinical material. When the search terms were widened to include **obsessive compulsive disorder** AND **sex** And **relationships** quantitative and mixed method studies were found. All of the quantitative studies used questionnaires, whilst the expert papers used case studies and critical analysis of theoretical papers. As none of the expert papers described themselves as research it was hard to assess the quality of the findings, although relevance to the current study was found.

There were a number of gaps highlighted during the process of the literature review. These included the need for further studies to better understand the etiology of out of control sexual behaviour (Faisander et al., 2012) and the need for models other than CBT to examine the connection between OCD and attachment difficulties (Wetterneck and Hart 2012). The Expert papers focused on early developmental issues and the appropriate psychoanalytic treatment of obsessional neurosis, with particular attention paid to the development of the superego and the Oedipus complex.

The re-occurring themes of the single case studies were the evidence of sexual difficulties arising out of an object relations difficulty during childhood. Such difficulties included intrusive parental sexualisation at an early age, unresolved Oedipal issues and a lack of boundaries between parent and child.

I will now go on to outline the theoretical construct that was used in the analysis of clinical data during the single case study.

2.7 Theoretical Construct Used in the Study

2.7.1 Introduction

The aim of this section is to consider OCD from a psychoanalytic perspective and to define the terms of reference for this study. The two concepts under examination here are object relations and obsessional neurosis. These concepts will be analysed using Melanie Klein's Object Relations Theory. Her theory regarding the regulation of love, hate and aggression in the unconscious mind of her child patients provides insight into the significance of good object relations, whilst helping us comprehend something of the etiology of obsessional neurosis and sexual development. Klein's concept of splitting located in the paranoid schizoid position is highly significant to this study.

2.7.2 Melanie Klein's Object Relations Theory

Klein's model of object relations was gathered during her work with children beginning in the early 1920's. It was Karl Abraham, her second analyst, who began to refine Freud's Psychosexual Theory, where pre-genital phases are driven by a pursuit of primitive gratifications, without thought for the object. Abraham introduced revisions of the theory in order to account for the existence of both benign and destructive elements in pre-genital sexuality. Abraham recognised that in the genital

phase, libidinal urges are directed towards others not in primitive oral and anal ways as proposed by Freud, but as potential sexual love objects, introducing loving and destructive behaviours towards the object. This discovery will be considered later in this chapter when considering the influence of child sexuality for the adult OCD individual. With Abraham's premature death, it was left to Klein to research this further.

Klein developed her Object Relations Model through observing and interpreting the play of her child patients (Klein, 1929, 1930). In this way, she was able to access the child's internal world and thereby access their deepest unconscious wishes and fears. Initially Klein felt that she had found evidence that supported Freud's developmental theories gathered during his work with adult patients, relating to the function of the unconscious mind and its influence on everyday relating. Freud (1918) found evidence that the contents of the unconscious mind come from early experiences, including trauma and frightening phantasies, especially the primal scene; that is the parents' observed sexual relationship which, according to Freud, takes the form of a perturbing sexual memory which is violent in nature. As this is experienced at too young an age to use language to articulate, and if it remains unprocessed, it is liable to return in the form of conversion symptoms or obsessions at a later point in the life of the child.

As Klein developed her understanding through the research method of observing the play of her young child patients she chronicled the infant's early states, including instinctual turmoil, sadistic cruelty and intense anxiety (Klein, 1932, 1935,

1940). As this differed from Freud's understanding, Klein gradually moved away from his emphasis on libidinal drives which had been the focus of her early papers, and instead began to highlight the role of aggression in the unconscious mind of her patients. Despite this change in emphasis, Greenberg and Mitchell highlight that:

> *'Klein saw genital, oedipal sexuality in every nook and cranny of the child's world.'* (1983, p.121)

Klein's model for early object relations describes a primitive psychic life, which centres on the mother's body, and is characterised by unconscious cannibalistic attacks. According to Klein, the infant's regulation of early persecutory anxieties involves warding off dangers of internal and external bad objects and was initially termed as the 'paranoid position'. The paranoid position is dominated by the splitting of good and bad objects, which result in a split between love and hate. Klein had a different interpretation of the primal scene, which she considered to be related to the child's projective phantasies or sexual ideas. Klein placed an emphasis upon the way in which the infant projects hostile and destructive inclinations into the parents' coitus, including phantasies about father and mother being bitten, torn, cut or stamped to bits (Klein.M., 1930). Klein proposed that this experience of the primal scene is when the child's curiosity is first provoked and leaves the child feeling both excited and excluded from it. Klein noticed that this experience evokes anxiety, which is internalised as a result of the oral-sadistic introjection of the objects, and forms part of the gradually developing superego.

According to Kleinian theory, the superego is formed at an early stage of development and at a time when the infant is subject to very powerful and sometimes sadistic phantasies and at a point when the ego is disconnected from reality. Klein discovered that representations of objects and the influence they have within the superego become distorted through the child's own sadistic impulses. Klein (1932) highlighted that at every stage of development the way that the ego relates with its object mirrors exactly how the superego relates towards the ego, and by the ego towards the superego; suggesting a correlation in the interaction between the three positions.

These intense early anxieties contribute significantly to the etiology of extreme difficulty in relating in an intimate way for the obsessional patient. For if we agree with Klein that the OCD individual is involved in projecting out the harsh and critical superego on to his objects, this must then increase his fear of them. Whilst these phantasies are unconscious and never come into the conscious mind in the same form, the obsessional individual will describe a terrifying world filled with hostile objects, where he is in constant fear of persecution from both his internal and external world. Klein states that:

> *"If the anxiety becomes too intense, or if the ego cannot tolerate it, he will avoid the fear by withdrawing from the mechanism of projection, which would stop any further introjections of objects. However, this would prevent any growth into reality and put him at the mercy of his already introjected objects".* (1932, p.204)

What ensues is a constant fear of attack, which Klein describes as '*probably one of the deepest sources of hypoch*ondria' (1932, p.204) It seems that unsuccessful developmental progression into reality testing leaves the obsessive individual with frightening internal objects, which have to be defended against by obsessional ruminations or behaviours. From Klein's research she was able to provide evidence that her child patients had active sadistic sexual theories at this stage of development, which involve maximum sadism and provide a fixation point for paranoia. Klein suggests that libido is also active at this time and the libidinal relations to the real objects and the influence of reality lessen the fear of internal and external antagonists. Libidinal development is closely connected to the child's desire to know, and because it emerges prior to the ability to speak, the child becomes frustrated and can feel both a longing and rage towards the object. Klein describes this as the polarisation where the life instinct (libido) meets the death instinct. Klein suggests that:

> "W*e may regard the child's fixation at the oral-sucking level as an expression of the force of its libido and the early emergence of its oral sadism as a sign of the ascendance of its destructive instinctual components". (1932, p.180)*

In normal development, the child's belief that there are good 'others' out there enables his object relations to emerge in a stronger position. For the obsessional child, the nature of the external objects can be less hopeful as they are likely to have been failed in some way by their object. This idea is significant as these early experiences form the foundations for the adult sexual relationship, and the quality of the adult sexual relationship is likely to replicate aspects of the early object relations.

Klein suggested that harsh internalised objects are constantly being projected into the external world whereby perceptions of real objects in the external world blend with the projected image. Klein proposed that:

> *"The early establishment of harsh superego figures actually stimulates object relations in the real world, as the child seeks out allies and sources of reassurance, which in turn transform his internal objects. This is also the process for repetition compulsion, which involves a constant attempt to establish external danger situations to represent internal anxieties"*. (1932 p.170)

In her paper "Mourning and its' Contribution to Manic Depressive States", Klein (1940) reports that there is a close connection between the reality testing that goes on in normal mourning, as described by Freud (1917), and early states of the mind. Where there has been a relational failure, the testing of reality is so unbearable for the child that an obsessional defensive structure is employed, as object failure is too catastrophic to contemplate.

Klein describes how the child's unconscious mind is constructed by actual experiences with parents that are shaped by deep unconscious phantasies. These internal objects are then altered by unconscious phantasies and impulses. Klein is clear that where the introjected object is harsh or unavailable, due to a relational failure, the death instinct is unresolved and the child has to find other mechanisms to cope with the persecutory anxiety. This relational failure can be catastrophic, with one

result being the development of obsessional neurosis, which provides a mechanism within which to contain intense anxiety. It is my hypothesis that one of the functions of OCD is to serve as a defence against intense anxiety, which has come about as a result of an object relation failure involving inconsistent and unpredictable external object relationships. This involves objects, who at times are experienced as nurturing, attuned and responsive, while at other times they are intrusive, insensitive or emotionally unavailable.

As Klein developed her understanding of the phenomenon, the paranoid position was renamed the paranoid schizoid position. Klein understood the paranoid schizoid position to be in the earliest stages of development representing a state of mind. In her early papers, Klein assumes that her states of mind/positions operate within the Freudian psychosexual phases, although she questions when such stages actually emerge. As Klein continued in her research, her understanding changed and in her later papers she suggests that the positions are much more fluid and can be lifelong.

In her paper 'Notes on some Schizoid Mechanisms' (1946), Klein tells us that:

> "*I have further suggested that the relation to the first object implies its introjection and projection, and thus from the beginning object relations are molded by an interaction between introjection and projection, between internal and external objects and situations"*.
>
> (1946, p.99)

She goes on to describe some problems of the early ego:

> *"Prominent amongst these functions is that of dealing with anxiety. I hold that anxiety arises from the operation of the Death Instinct within the organism, is felt as fear of annihilation (death) and takes the form of fear of persecution. The fear of the destructive impulse seems to attach itself at once to an object – or rather it is experienced as fear of an uncontrollable overpowering object ……. Even if these objects are felt to be external, they become through introjection of internal persecutors and thus reinforce the fear of the destructive impulse from within". (1946, p.100)*

From my work with obsessive patients, I notice that this process is employed to project persecutory anxiety originating from an internal object to an external object, which can then be controlled or neutralised by the obsessive ritual through a process of symbol formation. This unconscious process allows for the re-introjection of something more hopeful, a good object, which stabilises the anxiety for a brief period. Invariably OCD rituals become ever more complex as the anxiety continues to re-assert itself.

Whilst Klein's depressive position is not the focus of this study, it is important to mention as achievement of the depressive position signifies integration. Klein (1935) first describes the depressive position as when the infant begins to experience the object as whole, with characteristics that are both good and bad. Klein suggested

that the depressive position could be thought of as '*melancholia in statu nascendi'* (1940, p.126), that is 'in the process of coming into existence', because of the re-structuring of the object that occurs. The interchange between the depressive and paranoid schizoid position is taken up and developed by post-Kleinians, including Bion (1962). He concluded that these states fluctuate throughout life and are the material of psychic life. This included Klein's ideas that fragmentation of the object involves a sense of persecution and a failure to engage with the good object. This describes the challenge of obsessive individuals who are controlled by an impending sense of persecution or catastrophe without a good object to turn to for rescue or support. Bion suggests that in order to achieve integration, that is Klein's depressive position, the individual has to have the capacity to tolerate knowledge, truth and thinking. An object relations disruption hinders the possibility of integration. This disruption can be the outcome of diverse conditions, including: 'loss of mother' through neglect; inconsistent care giving and withdrawal or death, and can prove disastrous to the psychological health of the child and their capacity to tolerate anxiety.

In normal development, the object that is being mourned is the mother's breast and all it symbolises in the mind of the infant, including: love, goodness and security. These are felt by the infant to be lost as a result of his own uncontrollable greedy, destructive phantasies and impulses against mother's breast. Further distress about impending loss of the parents arise out of the Oedipus situation, which materialises in close connection with breast frustrations and is initially dominated by oral impulses.

Klein suggests that the sorrow and concern about the feared loss of 'good' objects during the depressive position, is:

> "*The deepest source of the painful conflicts in the Oedipus situation, as well as in the child's relations to people in general*". (1940, p.127)

In normal development, these feelings of grief and fear are overcome by various methods, however, where there is a relational failure, persecutory anxiety and paranoia can result. Betty Joseph (1966) takes up this theme and points to relational failure and subsequent development of paranoia as a possible cause of an obsessional neurosis. Thus providing evidence for a connection between early object failure and obsessional neurosis.

Klein proposes that from her observation of children, the depressive position operates alongside the Oedipus complex, which she locates towards the end of the first year of life. The Oedipus complex is an important consideration for this study as it provides a framework within which to understand the significance of love, hate and aggressive phantasies and how they may later be connected or observed in the obsessional patient and their intimate relationships. Freud saw the successful resolution of the Oedipus complex as necessary for later independent functioning; for it is only possible for the child to eventually find available sexual objects in later life if the dependence and incestuous wishes of the early years are overcome. Klein understood the Oedipus complex to be concerned with the struggle for power over, and destruction of, the rival parent, along with the fear of retaliation, thus moving

away from Freud's theory where the main drive was libidinal. Klein felt that the libidinal impulses only become challenging at a much later stage. Klein suggested that the child feels anxiety and guilt, not because of lust, but because of aggressive phantasies that accompany the libidinal impulses.

It is an integral part of the depressive position that the infant develops the desire for reparation, which includes love and respect for the object. It also involves acceptance of guilt, which can engender hope. Repair and restoration of the object are crucial at this stage. Hinshelwood (1991) describes reparation as the strongest element of the constructive and creative urges. He goes on to outline Klein's forms of reparation described in her 1940 paper. Of the three forms mentioned, the obsessional reparation is of most interest to this study:

> '*This consists of a compulsive repetition of actions of the undoing kind without any real creative element, designed to placate, often in a magical way*". (1991, p.414)

Hinshelwood describes how Klein initially agreed with Freud's view of reparation, that it was developed specifically to counteract the manifestations of aggression. Hinshelwood reports:

> "*Later she revised her view as she noticed that it 'entailed a great concern and activity to put things right... the desire to make reparation, to make good*

the injury psychologically done to the mother." (1991, p.414)

In her 1945 paper Klein reinforces the significance of reparation as being the outcome of the meeting of two opposing instinctual drives:

> *"The course of libidinal development is thus at every step stimulated and reinforced by the drive for reparation, and ultimately by the sense of guilt"* (Klein, 1945, p.410).

Three years before her death in 1960 Klein wrote a paper entitled 'Envy and Gratitude' (1957). In it Klein alters her approach to early object relations and moved away from the central role of sadism, replacing it with the concept of envy. Likierman (2001, p.173) notes this shift and cites Klein's revision when she says:

> *"In the unconscious mind, the good breast remains forever the prototype of 'maternal goodness', inexhaustible patience and generosity as well as creativeness. In a harsh world it provides the human individual with no less than the 'foundation for hope, trust, and the belief in goodness'.* [Klein, 1957, p. 182 as cited in Likierman, 2001, p.173)

Klein's Object Relations Theory with its emphasis on splitting, the function of aggression and the psychological need for reparation is of particular relevance to this

study and will be important to notice in the obsessive ruminations of the participant in the qualitative stage of the research.

2.7.3 Obsessional Neurosis

Freud first wrote about obsessional neurosis in a paper written in 1907 for a periodical titled 'Obsessive Actions and Religious Practices'. In it he provides an outline of the mechanisms of obsessional symptoms and suggests that both religious and obsessional rituals relate to repressed guilt with a sexual component. He wrote:

> *"It is found that the obsessive actions are perfectly significant in every detail, that they serve important interests of the personality and that they give expression to experiences that are still operative and to thoughts that are cathected with affect. They do this in two ways, either by direct or by symbolic representation; and they are consequently to be interpreted either historically or symbolically*. (1907, p.120)

He describes what might be thought of as 'everyday obsessions', such as rituals that are performed at the end of the day, as well as giving examples from clinical work where the obsession can be traced back to a sexual guilt. This paper was a prelude to a more famous paper where he documented the analysis of 'The Rat Man' in '*Some Notes Upon Obsessional Neuroses'* (1909). In the case of the Rat Man, the obsessional neurosis is traced back to his childhood sexual thoughts and

experiences. As a child Ernst Lanzer (the Rat Man) was overwhelmed with sexual thoughts and developed scopophilia, which in his case took the form of a strong desire to see a woman naked. This obsessive wish was accompanied by a fear that something dreadful would happen. Freud suggests that Ernst Lanzer's obsessional ruminations were formed by a combination of loving and aggressive impulses directed towards the people closest to him. Freud theorised that the accompanying phantasies and symbolic meaning of the obsessive ruminations originated in sexual experiences of childhood, with a particular connection to the harsh punishment for childhood masturbation and sexual curiosity relating to his nanny's female genitalia rooted in what Freud described as the anal sadistic stage. In theorising about the nature of obsessional neurosis, he concluded that the relation between love and hate in the obsessive patient is one of the most important characteristics to consider. Freud also recognised that obsessional neurosis is not easy to understand:

> '*The language of the obsessional neurosis – the means by which it expresses its secret thoughts – is, as it were, only a dialect of the language of hysteria; but it is a dialect in which we ought to be able to find our way about more easily, since it is more nearly related to forms of expression adopted by our conscious thought than is the language of hysteria*". (1909, p.382)

Ernest Jones (1918) recognised Freud as being the chief contributor to our understanding of obsessional neurosis. In his paper "Hate and Anal Eroticism in the Obsessional Neurosis" (1918), Jones also explores the etiology of hate. He points to the significance of the infant feeling loved by the parent, for it is in this experience

that the infant feels pleasure. Jones goes on to say that where this pleasure is not experienced, the child's annoyance and anger are then apt to pass over into chronic hatred, which becomes repressed only to re-surface in adulthood in the form of an obsessional neurosis. Freud wrote:

> "*Two impressions at once emerge from the brief survey of obsessional symptoms. The first is that a ceaseless struggle is being waged against the repressed, in which the repressing forces steadily lose ground; the second is that the ego and the superego have an especially large share in the formation of the symptoms".* (1926, p.113)

In the same paper he acknowledges that psychoanalysis still has to rely on doubtful assumptions and unconfirmed suppositions, but he considers obsessional neurosis to be fending off the libidinal demands of the Oedipus complex, that is namely a rivalry with the parent of the same sex for the love of the parent of the opposite sex.

Around the same time Melanie Klein was writing about obsessional neurosis, taken from her first-hand experience of analyzing young children. She reported that the etiology of obsessional neurosis originated from projected innate death instinct and cathected part-objects, as described below in the Erna case, rather than repressed guilt about sex as outlined in Freud's (1907) paper.

In her paper 'Personification in the Play of Children' (1929), Klein describes how she notices the obsessional behaviour of her young patient Erna who suffered

from a marked paranoia and persecutory anxiety. The play was dominated by thoughts of persecution, including being constantly spied upon. The times when Erna played the part of the child, the game ended in her escaping persecution. As the good child, she would become a rich and powerful queen who takes revenge on her persecutors. Klein noticed that:

> *"After her sadism had spent itself in these phantasies, apparently unchecked by any inhibition (all this came about after we had done a good deal of analysis), reaction would set in in the form of deep depression, anxiety and bodily exhaustion. Her play then reflected her incapacity to bear this tremendous oppression, which manifested itself in a number of serious symptoms. In these final phantasies all the roles engaged could be fitted into one formula: that of two principal parts—the persecuting superego and the id or ego, as the case might be, threatened, but by no means less cruel".* (1929, p.194)

Klein goes on to suggest that the wish fulfillment[1] evident in these games relates to the desire to identify with the stronger side in order to master the fear of persecution. This mastery was only possible through the mechanisms of displacement and projection. Klein provided clinical evidence in the following report:

> *"When Erna played the part of the cruel mother, the naughty child was the enemy; when she herself was the child who was persecuted but soon became powerful, the enemy was represented by the wicked parents. In each case there*

[1] Klein uses the term 'wish fulfillment' in her 1929 paper. This is a term much more closely related to a Freudian construct, which relates to a particular type of phantasy. Klein later developed a much more inclusive definition of phantasy as the content of the unconscious mind. (Spillus 2001)

> *was a motive, which could be made to appear quite plausible to the superego, for indulging in unrestrained sadism. By the terms of this agreement the superego was to take action against the enemy as though against the id. The id, however, in secret, naturally pursued its predominantly sadistic gratification, the objects being the primal ones. Such narcissistic satisfaction as accrued to the ego through its victory over foes both without and within helped also to appease the superego and thus was of considerable value in diminishing anxiety. This compact between the two forces may in less extreme cases be relatively successful: it may not be noticeable to the outside world nor lead to an outbreak of illness. But in Erna's case it broke down completely because of the excessive sadism of both id and superego. Thereupon the ego joined forces with the superego and tried by punishing the id to extract a certain gratification, but this in its turn was naturally a failure. Reactions of intense anxiety and remorse set in again and again, showing that none of these contradictory wish-fulfillments could be sustained for long". (*1929, p.194*)*

This indicates that the obsessional neurosis, as evident in Erna's play, acts as a defence against an early relational failure where the parents have been introjected as cruel and persecuting. Also present is a fear of the child's own destructiveness, and this takes the form of intense hatred of the self.

In the same paper Klein (1929) reports on a severe case of obsessional neurosis in a child aged two and three-quarters. Rita's obsessions were characterised as complicated sleep rituals and other obsessions, usually found in adults. The main

ritual was of her doll being tucked up in bed with an elephant on guard, preventing her from getting up to sneak into her parent's bedroom to either harm them or take something from them. The elephant (a father-imago) took on the role of the one who stands guard. From the age of eighteen months Rita saw her father in this position, by a process of introjection. Unconsciously, Rita wanted to triumph over her mother by being the one to be next to her father and halt the possibility of a sexual couple. The reactions of rage and anxiety when the 'child' was punished in these games showed that in her own mind Rita was enacting the authorities, who inflicted punishment and the child who received it.

The wish fulfillment apparent in this game is found in the elephant who managed to keep the doll from getting out of bed. The character of the doll embodied the id, whilst the preventing elephant represented the superego. The wish-fulfillment element involved the defeat of the id by the superego. From this example it can be noticed how Klein was able to observe the development of the superego through the child at play.

Klein makes an important point when she suggests that in both sexes, the turning away from the mother who is an oral love-object, results from oral frustrations, and this frustrating mother persists in the child's mental life as the mother who is feared. Klein reminds us that the onset of the Oedipus conflict and the start of the superego formation has a tyrannical character, formed from the template of the pre-genital stages. Evolution of the superego towards genitality ultimately depends upon whether the prevailing oral fixation has taken the form of sucking or of biting.

The dominance of the genital phase in relation to both sexuality and the superego requires a sufficiently strong preoccupation to the oral-sucking stage. The relevance of this idea is that oral sucking suggests an ability to take a good feed in a nurturing relationship as opposed to oral biting frantic or aggressive relationship. Klein goes on to propose that:

> "T*he closer the development of the superego and the libidinal development progress towards the genital level, the more closely the figures of the real parents will phantasised and wish-fulfilling identifications occur. If introjections at this point are tyrannical in nature then it is possible that an obsessional neurosis will develop as a defence against the death anxiety".*
> *(*1929, p.198*)*

Klein observed that as the obsessional individual advances to the genital stage, his introjected images do not follow the usual developmental path of becoming more friendly and caring. As a result, the superego develops obsessive ruminations in order to overcome anxiety.

In her paper 'Obsessional Neurosis and Superego' (1932), Klein speaks to the etiology of an obsessional neurosis when she evaluates Freud's (1918) paper on his patient the Wolf Man. Klein notes that during the analysis Freud found that the child had been seduced by his sister and this disturbed his relationship to a female object, which resulted in his passive feminine side being emphasised. Freud's analysis of the

wolf dream uncovered that he had repressed loving feelings towards his father. Freud suggested that the child's fear of being devoured by a wolf was not only related to fear of castration, but more significantly, an anxiety regarding his father, which is likely to have contributed towards his abnormal development. Freud noted that the child became naughty shortly after the wolf dream and subsequently developed an obsessional neurosis. Klein (1932, p.160) suggested that the obsession developed as a defence against aggression directed towards his father. This could be explained by the fact that a much greater anxiety or primary sadism had been dealt with in an abnormal way. Klein concludes that where obsessional features appear strongly and early in an infantile neurosis, we must surmise that very serious disturbances have taken place. This conclusion was based upon clinical cases where she was able to trace abnormal development back to overly strong sadism, which had not been successfully modified.

When Klein wrote about manic-depressive states she also described much of what can be noticed in the clinical work with the obsessive patient, which would suggest a similar developmental pathway:

> *"The ego tries to defend itself against internalised persecutors by the processes of expulsion and projection. At the same time the dread of the internalised objects is by no means extinguished with their projections, the ego marshals against the persecutors inside the body with the same force as it employs against those in the outside world. These anxiety contents and defence mechanisms form a basis of paranoia".* (1935, p.146)

The self-reproaches of the depressive, as described here, can also be observed in the obsessive individual. Klein adds:

> *"But to my mind the ego's hate of the id, which is paramount in this phase, accounts even more for its feelings of unworthiness and despair than do its reproaches against the object. I have often found that these reproaches and the hatred against bad objects are secondarily increased as a defence against the hatred of the id, which is even more unbearable. In the last analysis it is the ego's unconscious knowledge that the hate is indeed also there, as well as the love, and that it may at any time get the upper hand (the ego's anxiety of being carried away by the id and so destroying the loved object), which brings about the sorrow, feelings of guilt and the despair which underlie grief. This anxiety is also responsible for the doubt of the goodness of the loved object".* *(*1935, p.154*)*

We see here that the manic-depressive has hatred towards the self, which is not a characteristic of the obsessive individual. Nonetheless, what Klein reports about the manic depressive also reflects something of the position of the obsessional patient; that is, he has introjected a whole and real object, but has not been able to achieve a full identification with it, or, if he has got as far as this, he has not been able to maintain it. This may be because the persecutory anxiety is too great, and so as a defensive action, fragmentation of the object is required. This fragmentation is what Klein describes as part objects, where the immature mind strives to keep the good object protected from the hated and hostile elements of the bad object. Frightening suspicions and anxieties get in the way of stable introjection of a good object, or the

'real object' may be experienced as persecutory. There is little capacity to maintain the introject as a good object since doubts and suspicions turn the loved object into a persecutor again. Thus, the obsessional patient's relationship to whole objects and to the real world is still influenced by his early relation to internalised part-objects. Thus, just like the manic-depressive individual (reclassified in 1980 as bi-polar in the DSM 111), the obsessional patient goes on to develop a strong and acute power of observation of the external world and of real objects. The image is distorted, since his persecutory-anxiety requires him to constantly be on guard for any perceived threat. Klein reports that where the persecutory-anxiety for the ego is dominant, a stable identification with another object, as it really is, and a full capacity for love, is not possible. This clarifies why a sexually intimate relationship in adulthood can be problematic. A whole-object relationship is not possible while the persecutory-anxieties are still operating so strongly; he cannot endure the additional burden of anxieties for a loved object as well as feelings of guilt and remorse, which accompany this depressive position. Klein states that:

> *"Moreover, in this position he can make far less use of projection, for fear of expelling his good objects and so losing them, and, on the other hand, for fear of injuring good external objects by expelling what is bad from within himself".* (1935, p.155)

Having discussed the similarities with bi-polar disorder, it is important to briefly consider what differentiates obsessional neurosis from other mental health conditions. In writing about the development of schizophrenia, Klein (1946) recognised that in schizoid mechanisms the destructive impulse is turned against the object from the

very beginning. This is first expressed in phantasised oral-sadistic attacks on the mother's breast, which quickly turn into sadistic attacks on her body. This evokes persecutory fears, which seem to be significant in the development of paranoia and schizophrenia. Furthermore, the defences of the early ego, primarily the mechanisms of splitting the object and the impulses, idealisation, denial of inner and outer reality and suppressing of emotions, as well as persecutory fears of being poisoned and devoured, are found in the later symptomatic picture of schizophrenia. Klein found that where the persecutory fears are so strong it is impossible for the infant to move from the paranoid schizoid position to the depressive position. This failure may lead to a strengthening of persecutory fears and re-enforce the fixation points for the group of schizophrenias. Furthermore, the outcome of severe difficulties arising during the period of the depressive position may lead to manic-depressive disorders in later life. Klein concludes that in less severe disturbances of development, the same factors strongly influence the choice of neuroses. The depressive position is a central role in the child's early development as it supports the introjection of the object as a whole. This gives rise to feelings of mourning and guilt and evokes a desire for reparation, which imply significant advances in the infant's emotional and intellectual life. This point is also a crucial moment for the development of neurosis or psychosis.

Betty Joseph (1966) reminds us of the special research value of treating children. She describes the unique opportunity to observe primitive and fluctuating anxieties being expressed directly and at the same time the shifting defensive processes being mobilised in the playroom. Joseph points out that through analysis it can be noticed how the obsessional neurosis connects to a defensive preference going

back to the earliest times of life. The child's preferred defences can be used with varying rigidity against a range of anxiety constellations, resulting in a different clinical picture according to the underlying anxieties. Joseph was able to demonstrate the process of a little boy primarily using defences of splitting, projective identification, and omnipotent control over his objects, which then progressed from a paranoid organisation to an obsessional one during the first two years of his analysis.

Joseph highlights that it was not until Klein's (1932) paper that the connection between paranoia and obsessional neurosis was understood. Joseph describes in some detail the early period of her analysis of the little boy, to show how it was possible to show the development from a paranoid organisation to an obsessional organisation, which confirms the significance of Klein's paper as it lays out a possible blue-print to aid our understanding of the internal workings of the mind of the obsessional patient. Joseph suggests that the movement involved the drawn-out projection of violent parts of the self into his objects, followed by an extreme persecutory anxiety. Over time the analysis with the child focused on the projective process and slowly began to build up confidence in the object's capacity to contain and modify his projections. Gradually this enabled the child to build up and maintain more successful obsessional defences in addition to, and partly replacing, his paranoid defence system. These obsessional techniques were defensive, controlling and magical in nature and encompassed the main areas of his relationships and thinking, and became the focus of clinical work.

2.7.4 The Challenges of Sexual Intimacy for the OCD Patient

The connection between the OCD patient and sexual behaviour has been the subject of considerable research covering different aspects of the problem. What is known about the challenges for the obsessional patient, in regard to sexual intimacy, is that any intimate connection, whether emotional or sexual, can present a risk, as the 'other' can be unconsciously experienced within a context of early relational failure, thus repeating a pattern of fear, hatred, mistrust or contamination. Descriptions of early object relations failure influence the development of impaired self-regulation, interpersonal and intrapersonal difficulties that can contribute to sexual depression, defined as despondency and dejection about one's sex life, poor sexual-esteem, defined as negative regard for and confidence in the capacity to experience one's sexuality in a satisfying and enjoyable way; or sexual promiscuity, sometimes including out of control obsessional sexual behaviours. In order to understand the mechanisms involved we will return to Klein's Object Relations Theory.

In 1930 Klein wrote about the importance of symbol formation in the development of the ego. She points to the central role of anxiety arising from sadistic attacks directed towards the objects, who in phantasy are bitten, cut or torn to bits. In order to avoid a counter attack, the child then defends itself through a process of projection. A fear for the lost object ensues and so a process of symbol formation follows in order to take back something of the feared lost good object. The process of symbol formation is an important concept to consider for this study, given the likelihood that the obsessive individual will be operating within the paranoid schizoid position where objects are experienced as either good or bad. Hannah Segal takes this

up and describes symbol formation as:

> *"An activity of the ego attempting to deal with the anxieties stirred by its relation to the object. This is primarily a fear of bad objects and the fear of the loss or inaccessibility of the good objects. Disturbances in the ego's relation to objects are reflected in disturbances of symbol formation. In particular, disturbances in differentiation between ego and object lead to disturbances in differentiation between the symbol and the object symbolized and therefore to concrete thinking characteristic of psychoses".* (1957, p.392*)*

Segal cites Ernst Jones (1916) who thought about symbolisation as being an unconscious process that is connected to the self and immediate blood relations, connected to birth, life and death. Segal summarises Jones' theory by saying that when a desire has been given up because of conflict and repressed, it may express itself in a symbolical way and the object of desire, which has to be given up, can be replaced by a symbol.

Klein (1930) developed this further by demonstrating that child's play is a sublimated activity - a symbolic expression of anxiety and wishes. At the beginning of this paper, Klein reports that there are two things that are feared by the ego, the first is the individual's own sadism and the second is the loss of the object.

The relevance to OCD is two-fold. The first relates to the obsessive rumination itself whereby the feared bad object is expelled into external objects that can be controlled, or at least the phantasy of control, in order for the individual to have some release from distress. A process of symbol formation then occurs involving the focal point for the obsession, such as concrete objects being ordered or in repetitive actions, which then soothe the anxiety through a process of reparation, allowing the good object to be introjected. An example of symbol formation is noticed after an unconscious projection of the bad object due to aggressive impulses. The conscious thought which follows the obsessional action is "if I wash my hands until they *feel* clean, my family will be safe today". The feeling clean is not something physical but rather an internal calming. This action involves the neutralising of aggression in the hand washing in some kind of obsessional reparation that takes on a magical form, in order for the good object to be re-introjected.

The second point relates to sexual contact. From clinical observations it has been noticed that an unconscious process unfolds operating out of the paranoid schizoid position. The internalised object (mother) is projected outwards and discarded whilst being subjected to intense hatred. This allows a space for the sexual partner to briefly become the good object during coitus. After coitus, the obsessional ego develops an intense guilt for their actions and fears retribution at the hands of its original object (mother). Positions are then reversed, the sexual partner returns to the bad, persecuting object position, which is rejected, and mother is re-introjected as the good object. In order for this to happen the ego begins a process of sublimation, which occurs in order to provide a sense of restitution or repair to the original object

(mother). This can usually be observed in the changing allegiance towards objects. Anxiety related to this is neutralised through an obsessive ritual, whose function is to reduce anxiety; obsessional reparation is made and the sense of guilt is eased. This meets with a pre-condition that Klein outlined for the development of restitutive tendencies and of sublimations in that pressure exerted by the superego is reduced and felt by the ego as a sense of guilt. The intense unconscious guilt comes from the genital impulses, the desire for sexual connection and the awareness of the intense hatred and sadistic impulses felt towards the internalised object. Klein's view of symbols, that is the displacement of affects and interests onto new objects, fits with what is being noticed clinically to varying degrees, in terms of sexual expression, sexual communication and sexual discovery. During psychotherapy sessions OCD patients unwittingly describe an unconscious process whereby, after a hostile separation from the object occurs, there is a desperate attempt for reparation. This is achieved with the help of obsessive ruminations or repetitive actions, which seek to repair the damage caused. Likierman reports:

> "*Klein explains symbol formation by suggesting that anxiety leads the child to abandon frightening objects and seek out new reassuring ones in the world around him. But each new object needs to represent, or symbolise, what has been abandoned and thus lost through fear… Klein provides an inspiring idea of the human quest to replace lost experience as the foundation of symbol formation".* (2001, p.80)

Klein describes how, in normal development, the increase of libidinal mechanisms and associated reductions of destructive impulses lessen the sadistic

tendencies that were once directed to the object. From my observation, the obsessional individual still operates within the paranoid schizoid position and therefore the destructive impulses are not significantly reduced.

In summary identifying the defences being used helps to pinpoint the developmental phase the patient is operating within. If the patient in the single case study is operating in the paranoid schizoid position, splitting and projective identification will be evident. Omnipotence in thinking prevails and the sense of reality is intermittent and precarious.

Segal (1957) highlights the differences in symbol formation during the paranoid schizoid and depressive positions. She suggests that where the depressive position has been reached the object is felt as a whole object. Where there is an awareness of separation between ego and object, ambivalence is felt. The ego struggles with ambivalence; guilt, fear and loss, and a striving to re-create the object characterises the relationship. According to Segal:

> "*The symbolic equations are felt to be the original object used to deny the ideal object and control the persecuting one. A suitable symbol, which is identified as available for sublimation, is felt to represent the object but has its own characteristics. In the depressive position separation from the object can be tolerated and guilt, ambivalence and loss can be experienced".*
>
> (1957, p.393)

This awareness supports the task of this study as it is a fundamental aspect of the hypothesis of this study is that in obsessional neurosis, the individual operates within the paranoid schizoid position whereby the good object is preserved by splitting and investing the bad object in the sexual partner who, in sexual relations, restores the good object by becoming the good object for internalization.

Chapter 3 Methodology

Introduction

This chapter describes research methods used in psychoanalysis and the method and design chosen for this study.

3.1 Research and Psychoanalysis

3.1.1 Background

Psychoanalysis as a subject of scientific research has had to overcome numerous obstacles with the debate centering on the meaning of science and the epistemological status of experience. Glover (1952) speaking on the shortcomings of psychoanalytic research said that there is ‘‘no effective control of conclusions based on interpretation, [and this fact] is the Achilles heel of psychoanalytical research’’. (p. 405)

Edelson (1985) argues that psychoanalysts should conform to the canons of procedure and reasoning that characterise science, especially when clinical data is used to support the psychoanalytic hypothesis. The epistemological question of how psychoanalysts justify knowledge requires the development of a rigorous approach to human subjectivity.

Wallerstein (2009) in his paper ‘What kind of Research is Psychoanalytic Science’ defines the challenges that psychoanalysis has confronted in its’ claim that it

is indeed a science. This challenge began with Popper (1963), who dismissed psychoanalysis as a pseudoscience.

Hinshelwood (2013) plots the history of discontent to psychoanalysis being an effective treatment. (Mason 1984; Crews 1993; 1998; Fish 1989 and Webster 1995) Hinshelwood reports that the multiple strands of criticism need careful attention and cites Milton (2004, pp-79-98) who breaks down the criticisms into the following categories:

1. Critics of the truth and knowledge: Popper, Cioffi and Grunbaum.
2. Critics who question Freud's stature and originality: Roazen, Ellenberg and Sulloway.
3. Critics from political and ideological perspectives: Millett, Timpanaro, Szasz and Rycroft.
4. Patient critics: Webster, Crews and Masson.

   (Milton 2004, p.79-98 cited in Hinshelwood 2013 p.7)

Hinshelwood recognises that to the outside world the onslaught of criticism must seem convincing but within psychoanalysis these 'schisms attract bitterness and intransigence'. (Hinshelwood 2013 p.8) When preparing this study careful consideration was given to its' design. The use of a mixed-method design seemed important as a small attempt to break down something of the intransigence spoken of by Hinshelwood, as well as demonstrate that qualitative and quantitative methods can be a useful paradigm in psychoanalysis.

3.2 Methods of Psychoanalytic Research

At the outset of the project it was important to examine various approaches to the research of psychoanalysis in order to decide upon the most suitable method for this study. The main objective was to discover if there is a connection between object relations (as described by Klein), problems with sexual intimacy and OCD.

3.2.1. Ethnographic Research Using Focus Group

Tuckett (2008) describes a study using grounded theory to define the process going on in a psychotherapy group between the psychoanalyst and the patient. The research process involved psychoanalysts meeting together to go through transcripts of group material to discuss interventions that were made in the group. This was based on implicit theorising about what the psychoanalysts does in the moment of the interpretation (Hinshelwood 2013). The rationale for the study was to reach a consensus concerning what constitutes psychoanalysis and to define a set of categories of interventions that a psychoanalyst might use. The outcome was that a consensus was agreed concerning what the psychoanalyst was actually doing in the psychotherapy group. Hinshelwood (2013, p. 13) points out 'this method resembles the ethnographic or anthropological fieldworker exploring the cultural assumptions of a group or society'.

A critique of this model includes the subjective experience of the psychoanalyst and the challenge of sustaining the subjectivity of the patient. Hinshelwood tells us that the hallmark of science is that there is a systemised method

for testing theories and that defining the dimension of the psychoanalytic model is really important.

This model was not considered for the current study as “grounded theory provides a methodology to develop an understanding of social phenomena that is not pre-formed or pre-theoretically developed with existing theories and paradigms." (Engward, H. 2013)

3.2.2 Process Research

Process research can be described as a method, which analyses clinical records, written or recorded to gather themes to generate objective data, which is then used to generalise themes across psychoanalysis. As a method it aims to conform to a normal process of naturalistic observation. (Hinshelwood 2013) This method was not suitable for the current study.

3.2.3 Single Case Study

Single case studies provide an opportunity to test psychoanalytic theory clinically. This method was used by Freud to test what was being observed clinically and through the use of inductive reasoning to construct psychoanalytic theory.

Hinshelwood (2013) ‘Research on the Couch’ model provides a response to the critique of Popper (1963) by providing a model where psychoanalytic knowledge

can be tested to meet with Poppers criteria for scientific truth. This is that theory must be validated by the criteria of empirical falsifiability. Hinshelwood argues that the clinical case study provides a primary source for psychoanalytic knowledge where a hypothesis can be formulated and tested to be true or false. This concurs with Ritvo (2001) who suggests that:

> "*The case study is a primary building block in the systemisation of clinical knowledge*". (Ritvo 2001 p.66 cited in McGehee 2005)

Hinshelwood (2013) highlights the importance of countertransference as an instrument for subjective observation. He notes the change since Freud (1916-1917) first claimed the need for the interpretation of countertransference 'to tally' with something in the patient (Hinshelwood 2013 p.452). This change, beginning with Heimann (1950), seems to be more concerned with the attunement between the psychoanalyst and what tally's for the patient. Since that time psychoanalytic researchers have struggled with the precise relation between the researcher's and patient's experience and how they converge to provide data evidence. (Hinshelwood 2013) A psychotherapist's emotional response to their patients are believed to hold clues to a patient's important relational dynamics (Hayes, 2004) and it is this, which can be turned into clinical data through observing the effects of interpretations. This is what Hinshelwood (2013) describes as a change occurrence.

Hanly (2013, p. xi) writing about Hinshelwood's model for psychoanalytic research tells us that:

"Hinshelwood provides a model that integrates two antagonistic views; that is that psychoanalysis is an empirical natural science seeking a causal explanation of the dynamic and structure of mental life. The other is that psychoanalysis is a hermeneutic science that interprets the meaning of formative experiences in life".

Rustin (2014) in his critique of Hinshelwood's (2013) model highlights that it provides a scientific method for doctoral students of psychoanalytic theory to test their clinical hypothesis in an accountable process.

Holmes (2013, p 160) cites Midgley and Frosh as he reports that there is 'an increasingly strong link between psychoanalysis and qualitative research (Midgley 2006), and that psychoanalytically informed research methodology has recently been incorporated into critical psychology. (Frosh 2003a) He points out how Gough (2004) used a psychoanalytic approach to challenge discursive psychology and that before this the emotional dimension of identity had not been adequately considered. Gough argues that psychoanalytic concepts can enhance understanding when "reading interview transcripts, where emotion (especially anxiety) seems to be present". (Gough 2004, p. 263 cited in: Holmes 2013, p.161) Holmes describes how consideration of the unconscious material of the patient enriches and deepens the clinical data. His paper focuses on the function of the researcher's reflexivity in elucidating unconscious processes. He describes the 'free association narrative interview' (Hollway & Jefferson 2000, 2008) a research tool based on the 'principles of free association'. (Freud 1925) The aim of the researcher was to have minimal input, allowing the interpretation of the clinical data to be completed during the data

analysis phase rather than during the interaction with the interviewee. Through the analysis of his personal emotional reactions during the interview, Holmes (2013) was able to capture the psychoanalytic processes of "projective identification" in the interviewee as well as "splitting and projection" that affected both the researcher and the interviewee.

Harvey (2017) used an adapted version of the psychoanalytically informed research interview from other studies, including Stromme et al. (2010), Cartwright (2004) and Kvale (1999). She highlights the emotionally demanding nature psychoanalytically informed research due to the dyadic relationship that forms during the interview process. Attention is drawn to the importance of the ongoing resonance between the researcher and the participant and reflects the working alliance where conscious, preconscious and unconscious levels can influence the outcome of the interpretation. This subject has been written about by other authors including Stromme et al., (2010), Mitchell & Irvine (2008) and Hollway & Jefferson (2000). Dickson-Swift et al., (2006) highlight the need to continuously strive to balance between the dangers of being too close or too distant from the participant.

3.3 Method Chosen

Careful consideration was given to the method for the current study. I had a strong desire to use a mixed method and as part of a reflexive process discussed the benefits and pitfalls of using quantitative data, initially in the research seminar group and then with her academic supervisor. It was recognised that a quantitative study is

highly unusual in a psychoanalytic research project but that the benefits of a mixed method, including psychoanalytic concepts to access unconscious meanings through the triangulation of transference and countertransference material, using Hinshelwood's 'Single Case Study' method would be an interesting project. Creswell & Tashakkori, (2007 p.207) tell us that:

'A strong mixed methods study starts with a strong mixed methods research question or objective'. They suggest that *'a strong mixed method study demonstrates the need for mixed methods to answer research questions that include clearly interconnected qualitative and quantitative components. It should present distinctly identifiable qualitative and quantitative data that are analysed and presented separately. The conclusion of the study should be based on the results of both the quantitative and qualitative data and finally that the results of the two strands of the study are brought together to form a conclusion'*.

Creswell & Plano Clarke (2007) helps us to consider the most useful form of questions to ask depending on the sequence of data collection. Where the study involves concurrent quantitative and qualitative data collection an appropriate question would be ''Do the quantitative results and the qualitative findings converge?'' (Creswell & Plano Clark, 2007, p. 107) Where the data collection is more sequential a useful question might be ''How do the follow-up qualitative findings help explain the initial quantitative results?'' or ''How do qualitative results explain (expand on) the experimental outcomes?'' (Creswell & Plano Clark, 2007 cited by Creswell & Tashakkori, 2007)

Mertens (2007) highlights the transformative necessity for changing the lives of participants in a study and discusses how it might affect the research questions, data sources, design, conclusions, and policy recommendations in a ‘‘cyclical transformative’’ way. Bryman’s (2006) paper is based on a content analysis of 232 social science articles in which quantitative and qualitative methods were combined. Analysis of the studies found that among the quantitative strand, the structured interview and research using questionnaires within a cross-sectional design were most widely used. Whilst among the qualitative strand the semi-structured interviews with a cross-sectional design were most evident. Bryman (2006) found that the rationale given for employing a mixed-methods research approach and the ways it was used in practice did not always correspond. He goes on to describe the coding for the combining of quantitative and qualitative research using Greene et al. (1989) five - point model, which includes:

1. *Triangulation*: convergence, corroboration, correspondence of results from different methods. In coding triangulation, the emphasis was placed on seeking corroboration between quantitative and qualitative data.
2. *Complementarity*: ‘seeks elaboration, enhancement, illustration and clarification of the results from one method with the results from another’. (Greene et al., 1989, p. 259)
3. *Development*: ‘seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions’. (Greene et al., 1989, p. 259)

4. *Initiation*: 'seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method'. (Greene et al., 1989, p. 259)
5. *Expansion*: 'seeks to extend the breadth and range of enquiry by using different methods for different inquiry components'. (Greene et al., 1989, p. 259, Bryman 2006, p.105)

This structure will be used to evaluate the current study in the Discussion and Conclusion in Chapter 6 of this thesis.

3.3.1 Quantitative Data - Structured Interview

Careful consideration was given to the choice of questionnaires used in this study. I initially discussed this with my clinical psychology peers who had extensive experience of using psychometric measures in their work and then with my academic supervisor and seminar leader. The questionnaires that were eventually chosen have been validated through extensive use and testing in the field.

During the first year of the study the design included the use of the Adult Attachment Scale (AAS), (Feeney, Nollar & Hanrahan, 1994) to capture the relational problem present in the sample. However after some careful consideration at the Supervisory Board this decision was revised. I felt that Klein's Paranoid Schizoid position better described the unconscious process that was being noticed in the consulting room and I did not want to move the theoretical construct to an attachment one. The Board was concerned that as I was not planning to make a connection

between the AAS results in the quantitative study and Klein's Paranoid Schizoid position (as a theoretical construct for the qualitative study), the use of two different theoretical constructs would prove problematic and so the AAS was discarded.

The Obsessive Compulsive Inventory (OCI) (Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., & Amir, N., 1998) was chosen as it was already being used to assess the level of OCD symptoms of patients entering the NHS Psychological Therapy Service and has validity within an acceptable range. The Sexuality Scale (Snell & Papini, 1989) was agreed in discussion, through personal communication with a leading academic in the field of human sexuality.[2]

3.3.2 Demographic Questionnaire (see Appendix G)

This (unvalidated) demographic questionnaire covered six areas that were identified as having a potential to impact upon the ability to develop a healthy attachment and sexual relationship. Defining a sexual identity was considered to be significant as it identifies conscious sexual identification and an understanding of self. It was recognised that sexual identity is a complex phenomenon that may have fluctuated over time. A literature review on the topic revealed a relative scarcity of studies on sexual dysfunction in OCD, despite apparently high incidence in up to 54 to 73% of patients (Freund & Steketee, 1989; Monteiro & Noshirvani, 1987; Staebler & Pollard, 1993; Aksaray & Yelken, 2001).

[2] The Sexuality Scale was one of several questionnaires recommended by Professor Sandra Byers from New Brunswick University.

Marital status was gathered to identify the percentage of patients in a long-term relationship. The quality of that relationship was not examined. The marital status of parents was gathered to identify the percentage of the sample that had experienced divorce or separation within their family. This variable is significant as when compared with children with continuously married parents, children with divorced parents continued to score significantly lower on measures of academic achievement, conduct, psychological adjustment, self-concept, and social relations.

3.3.3 Validated Measures Used

The Obsessive Compulsive Inventory (OCI; Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., & Amir, N., 1998) (Appendix H) is a comprehensive self-report measure for assessing symptoms of Obsessive Compulsive Disorder. It contains 42 items rated on two five-point Likert-type scales: one measuring frequency of symptoms and the other evaluating the distress caused by the symptoms. The 42 items form seven subscales, which are based on symptom categories that are commonly found in Obsessive Compulsive Disorder: Washing (eight items), Checking (nine items), Doubting (three items), Ordering (five items), Obsessing (eight items), Hoarding (three items) and Mental Neutralising (six items). Foa et al. (1998) reported good to excellent internal consistency (range = .59-.96) for the full scale and subscales for patients with OCD, generalised social phobia (GSP), and post-traumatic stress disorder (PTSD), as well as for non-anxious controls (NAC's). The OCI was developed to encompass the variety of obsessions and compulsions presented by individuals with OCD and to allow comparisons of a wide range of scores among the severity of various obsessions and compulsions. Importantly, the

OCI not only provides information about overall OCD severity through the total score, but it also addresses the relative severity of the different recognised obsessions and compulsions. An additional advantage of the OCI over other measures lies in its validation with samples of patients who were diagnosed by experts as having OCD and other anxiety disorders, as well as with non-psychiatric controls (Foe et al., 1998). Thus, the OCI is intended to be applicable to the general population in assessing sub-clinical obsessional thoughts and behaviours. Good reliability and validity of the OCI and its subscales have been demonstrated with clinical and non-clinical samples. The scale accurately detects OCD and is sensitive to non-clinical OCD symptoms.

The Sexuality Scale (SS; Snell & Papini, 1989) (Appendix I) is a self-report questionnaire designed to measure three aspects of human sexuality: sexual esteem; sexual depression; and sexual preoccupation. The SS consists of 30 items arranged in a format allowing respondents to indicate how much they agree (versus disagree) with the statement. A five-point Likert scale was used, with responses for each item being scored from +2 to -2: agree (+2), slightly agree (+1), neither agree nor disagree (0), slightly disagree (-1), disagree (-2). During the coding, some reverse coding was required and two of the questions (11 & 14) were not included in the subscales but were added to the total score. Reliability for the questionnaire has been tested (Snell & Panini, 1989; Snell et al., 1992) with the three subscales demonstrating a reliable internal consistency and test-retest reliability. Evidence for the validity of the SS comes from a number of sources (Snell and Papini, 1989; Snell et al., 1992). Wiederman & Allgeier (1993) indicated that men score more highly than women on

the sexual esteem and sexual pre-occupation scales, which is relevant as it supports the findings of this study.

3.3.4 Thematic Analysis

The method chosen for the analysis of clinical data was Thematic Analysis. Bryman (2016) tells us that in spite of the apparent frequency of use in analysis of qualitative data, thematic analysis is an under developed procedure in that there are few specifications for the process. A theme is:

- A category identified by the analyst through his/her data.
- Relates to the research focus
- Builds on codes identified in transcripts or field notes
- Provides the researcher with the basis for a theoretical understanding of the data that can make a theoretical contribution to the literature relating to the research focus. (Bryman 2016 p. 584)

The National Centre for Social Research in the UK developed a framework described a 'matrix based' to assist the thematic analysis of qualitative data. This involves developing an index of central themes and subthemes that are represented in a matrix spreadsheet showing the list of cases and variables.

Ryan and Bernard (2003) recommend that when searching for themes the coder should be consider repetitions, categories, metaphors or analogies, transitions or

shifting of topics, similarities and differences, linguistic connections, theory related data and finally missing data. Whilst Bazeley (2013) is cautious about thematic analysis as researchers who report to have used it are 'frequently vague about themes that were identified or how themes emerge from the data. (Bazeley (2013) cited in Bryman 2016).

Researchers have used thematic analysis in different ways. Jones et al (2010, p. 109) began their analysis of data from a study of early retirement where an initial coding scheme was developed and indexing undertaken through comparison within and between cases. Brooks and Waters (2015) studying the content analysis of websites of elite schools in the UK used a detailed grid to record information and explored in discursive manner, the way in which these themes were constructed in websites and elsewhere. Bagguley and Hussain (2016) reconstructed key themes from their interviews with South Asian women through a thematic analysis of views and experiences expressed by the women.

3.4 Study Design

I had a target of 25 participants to be recruited for the structured interview stage. Actually, a total of sixteen volunteers were recruited during the triage stage of the assessment process conducted by SCPTS. None of the participants were referred by a care coordinator from the Community Mental Health Team, despite the publicity and education that went on beforehand. This may have been due to care coordinators managing very high caseloads and therefore not able to hold in mind 'extra' tasks,

such as recruitment to this study. The Psychological Therapists within the team were experienced in research, better able to hold the study in mind, and were invested in learning about the findings of the study.

3.4.1 Control Group

A control group was not used in this study. The methodology using a single case study fell within the 'extraordinary' circumstances of research in that a single case study does not seek to make claims about the findings but simply to notice what is going on in a given situation and perhaps suggest further studies. In order to understand the nature of the problem, the researcher looked into the prevalence of OCD in the UK. Current estimates suggest that 1.2% of the UK population will have OCD, which equates to twelve out of every 1,000 people (OCD UK Website). Of these, a disproportionately high number, specifically 50%, of all these cases will fall into the severe category. Some estimates suggest that maybe 2-3% of all those visiting their GP will be doing so because of OCD.

3.4.2 Consultation

Due to the nature of the study, consultation was sought with the NHS Expert by Experience Group prior to the commencement of the project. In order to demonstrate reflexivity, discussion focused on ensuring sexuality scale data was collected in a patient friendly manner. Feedback was sought regarding the publicity material and the format of questionnaires. I gave a presentation focusing on the rationale for the study, methods to be used, and how findings will develop our

understanding of the complexity and etiology of Obsessive Compulsive Disorder, as defined within this sample. This all met with the criteria described by Hollway and Jefferson (2013) and Thompson (2009) and Henwood (2008) concerning reflexivity.

3.5 Publicity for the Study

3.5.1 To Professionals

An information leaflet for professionals (Appendix C) was sent to the Community Mental Health Team, which is made up of Community Psychiatric Nurses and Occupational Therapists, who act as Care Coordinators, and a team of Consultant Psychiatrists. The leaflet outlined the Aims and Objectives of the study and invited the team to consider making appropriate referrals from their caseloads.

3.5.2 To Potential Participants

Patients expressing an interest in the study were given a Patient Information Leaflet (see Appendix D), which outlined what would be required of participants. The leaflet was made available within Information racks in the waiting area of the Community Mental Health Team building for patients to take.

3.6. Participants

Careful consideration was given to the inclusion criteria in order to make a viable study. Inclusion and exclusion criteria were agreed in discussion with the

clinical supervisor. It was decided that this study would be most suitable for those presenting with OCD (DSM V Axis 1, ICD 10 F42) rather than a diagnosis of OCD Personality Disorder (DSMV Axis 11) because of the short time scales for the second stage of the study. It was recognised that patients with Obsessive Compulsive Personality Disorder would need a longer settling in phase beforehand to address the OCD behaviours.

3.6.1 Inclusion Criteria

1. Patients within the Trust presenting with Obsessive Compulsive Disorder (OCD) (DSM V Axis 1 disorder, ICD 10 F42).
2. Patients who present with Mixed Personality Disorder (DSM V) that includes OCD as part of their difficulty.
3. Patients willing to give informed consent to participate in the project.

3.6.2 Exclusion Criteria

1. Obsessive Compulsive Personality Disorder (OCPD DSM V, Axis 11 disorder).
2. Patients presenting with a psychosis (DSM V, ICD 10 F29).
3. Patients presenting in crisis.
4. Patients not willing to give informed consent to the data being used as part of the study.

Participants were not excluded on the grounds of race, gender or sexual preference.

3.7 Ethics Approval

Ethics approval was sought from the NHS Integrated Research Application System (IRAS), the NHS Trust Research & Development department and the University of Essex Ethics Committee, prior to the commencement of the research (see Appendices A & B).

3.7.1 Main Ethical Issues

Careful consideration was given to the protection of patient confidentiality and to ensure that participants were protected during the study. This was considered under the following ethical principles:

3.7.1.1 Avoidance of Harm

As the researcher I held responsibility for ensuring a safe environment and context. This included being aware of the sensitive nature of the structured interviews. During the preparation stage, interview packs were made up and each pack was given a unique identifiable number. This same number was written on the consent form in order to correctly identify the participant. This was required in order to correctly identify the highest scoring participant for the second stage of the study.

3.7.1.2 Informed Consent and Confidentiality

All participants signed a consent form (Appendix E) for the structured interview, which was scanned and uploaded onto RIO, the patient computerised record. A note was added to the patient progress notes indicating that the patient had agreed to participate in the study, had signed a consent form and had completed a structured interview as part of a doctoral study into OCD. The anonymity of all participants was ensured by anonymising or removing all identifiable information prior to dissemination of data. Participants taking part in the qualitative study signed a second consent form (Appendix F), consenting to the recording of psychotherapy sessions. These recordings were encrypted immediately after each session.

3.7.1.3 Freedom from Exploitation

The project took into account ongoing consent of all participants. This was emphasised in the Participant Information Leaflet. It was recognised that participants may give informed consent in principle before the interview, but may change their mind just before or during. In such instances, participants reserved the right to withdraw their consent at any point in the process. With this in mind, the researcher confirmed the ongoing consent at the end of the interviewing process to allow participants to remove their consent if they wished. No participant withdrew their consent for their responses to be used in the study.

All information was treated confidentially in line with data protection regulations and the NHS Trust Information Governance Policy. This was outlined in the Participant Information Sheet.

3.8 Study Structure

3.8.1 Stage 1 Administration of Measures

The questionnaires were completed during an individual appointment lasting approximately 40 minutes. Before the structured interview began, the participant was asked to confirm that they were still willing to give consent and complete the questionnaires. All participants were given a copy of the Patient Information Sheet, which explained the purpose of the study. I also asked participants if they preferred to complete the Sexuality Scale questionnaire alone (*as requested by the Patient Experience Group)*. The rationale for this was to protect the dignity and privacy of the participant. Four participants completed the Sexuality Scale individually, the remaining twelve were happy for the researcher to ask the questions.

Each participant was offered the opportunity to debrief after completing the questionnaires. The process for recruiting two volunteers to the second stage of the study was explained again at this point. Only one participant stated that they were not willing to participate in the recording of psychotherapy sessions. All participants were told that they would be offered treatment as usual as part of the study and it would have no impact upon their treatment pathway within the service.

At the end of each interview I scored the questionnaires and added them to an anonymised database in preparation for data analysis. The completed questionnaires were then stored in a locked filing cabinet, in line with the Trust's Record Keeping Policy, until the research study had been completed. The completed questionnaires will be shredded once the doctoral thesis has been approved.

3.8.2. Statistical Analysis

The Statistical Programme for Social Sciences version 21 (SPSS v.21; IBM, 2011) was used for data analysis. In order to convert the demographic data, the descriptive values were given numerical values from 0-6 The Pearson correlation analysis was used to test the correlations between variables. The Pearson Correlation (r) is designed to take values only with a range from -1 to +1, inclusive. Statistical significance was set at a *p* level of less than 0.05. The Spearman's rho correlation was used to compare results with the Pearson's correlation due to the low sample size (*n=16*). Ultimately, the Spearman's correlation provided the most satisfactory process for analysing the data.

3.8.3 Stage 2 Qualitative Data – Single Case Study

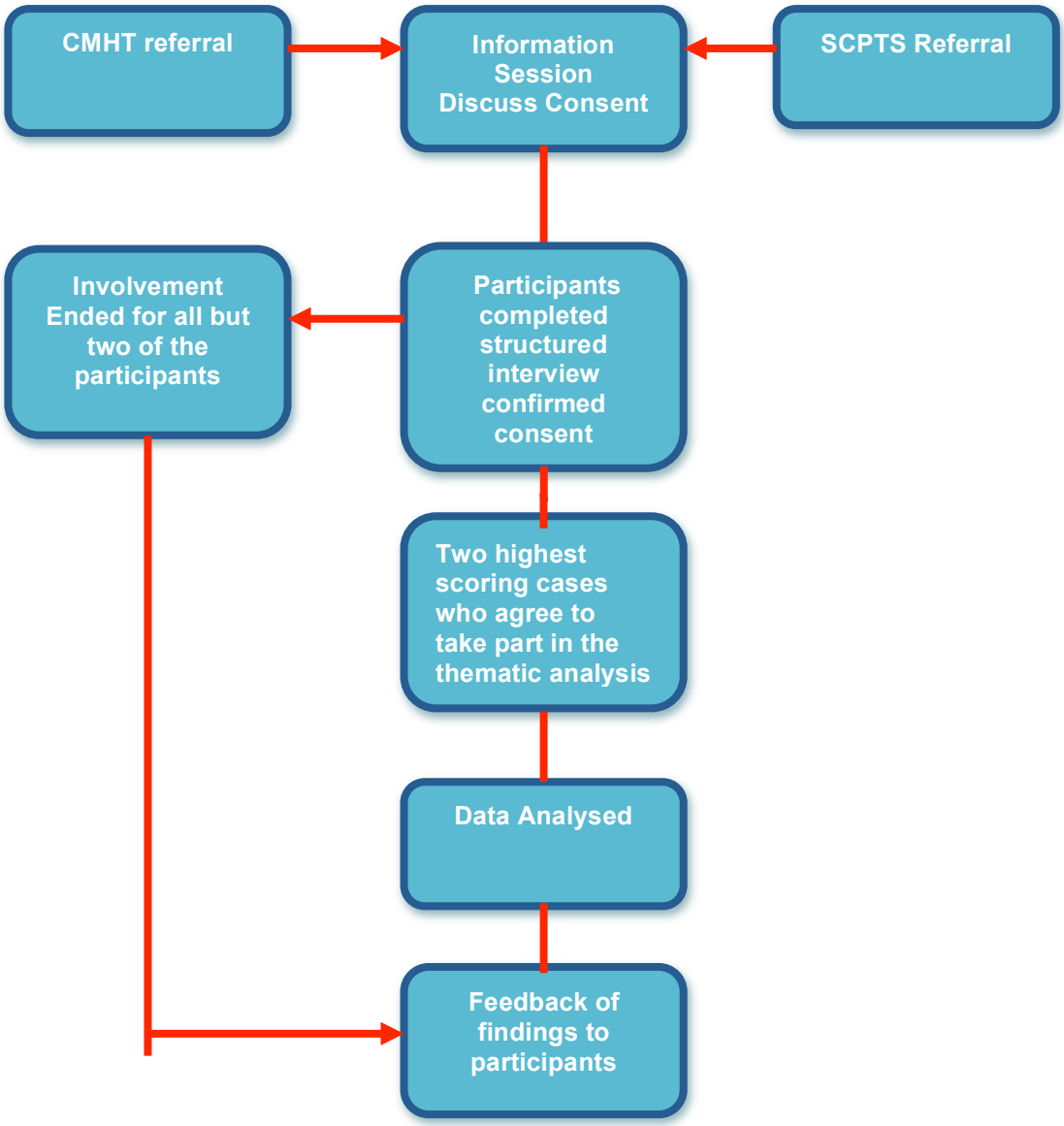
I gave careful consideration to the qualitative study as it presented a number of risks, including the risk of bias. As the study involved patients within a Mental Health Service, I was concerned that the participant may drop out due to the length of participation required or that they may become too unwell. I was also concerned that the clinical data could be open to misinterpretation. The analysing the clinical material needed careful attention, as coding of data alone could have lost important

contextual information. With this in mind, careful consideration was given to how participants were recruited to the qualitative study. Several options were considered and then ruled out due to possible claims of bias. Ultimately, it was agreed with the academic supervisor and seminar lecturer that recruitment should start with the highest scoring participants on the OCI questionnaire, as this would capture the severity of OCD whilst avoiding any bias in terms of any pre-established thoughts I may have had about the participants gained during the structured interview process.

Ultimately, the two highest scoring participants on the OCI questionnaire agreed to take part in the recruited for the second stage, the case study. The second participant was recruited in the event of the first participant dropping out at any stage. I began the psychotherapy sessions with the first participant in December 2015. The second participant had some anxiety about starting the psychotherapy and this delayed the start to mid-January 2016. Prior to commencement of the qualitative study, each participant signed a consent form agreeing to the recording of sessions. This was then uploaded onto their patient medical record and an entry made on the progress notes that the consent process had been completed. I entered into a contract with the two participants for a minimum of 20 sessions of once weekly brief psychotherapy. By the end of the study, Participant 1 attended 32 sessions and Participant 2 attended 28 sessions. All sessions were recorded and sessions of particular interest to the study were transcribed. As Participant 1 completed the treatment, the clinical data of Participant 2 was not analysed. Figure 1 below outlines the study pathway for participants.

Figure 1

Study Pathway



3.9 Interpretive Phase

3.9.1 Data Analysis

Before the interpretive phase began, I attended twelve hours of training to

learn about data analysis using Excel and SPSS software and fourteen hours of training related to Thematic Analysis and the NVIVO 10 software programme.

The recorded psychotherapy sessions were then transcribed prior to the coding of themes. Notes of transference and countertransference phenomena were recorded in the margins of the written data. Field notes relevant to the recorded sessions were entered as footnotes of the document. Recorded and transcribed data was managed in line with Data Protection Regulations and with the Trust's Record Keeping Policy. The protocol outlined in the Trust's Information Governance Policy (specifically Audio Recording) was adhered to at all times. The Trust fully endorses and adheres to the principles of Data Protection as laid down in the Data Protection Act 1998, the additional Principles for patient information in the Caldicott Report (2013).

All patient identifiers were anonymised or removed during the scribing process in order to protect confidentiality. On completion of the data analysis, the recordings were deleted as agreed with the patient. This was undertaken in accordance with Trust policy on the disposal of confidential waste. A signed and dated note was entered in the patient's clinical notes identifying the type and date of the recording and date and method of destruction.

Careful consideration was given during the editing process of the qualitative data to ensure the data was complete before coding began. A thematic analysis was

conducted following the structure suggested by Braun & Clarke (2006). A second coder was recruited from within the Psychological Therapy Team. The second coder is qualified to doctoral level and had completed a thematic analysis workshop. As the second coder was employed by the Trust, the conditions of the ethics approval were upheld.

In this study an initial sample of coding from a session was completed as a test and this was then discussed with the academic supervisor and in a seminar with doctoral peers and the lecturer. This reflexive process provided an opportunity for the work to be confirmed by peers, which is grounded in good practice protocols (Hollway and Jefferson, 2013).

The coding process involved looking for and noticing patterns of meaning in the narrative of the patient and adopting the techniques of going back and forth over the data, as suggested by Leuzinger-Bohlerber et al. (2006). The thematic system involved:

I. Familiarisation with the data - this first step in data analysis involved listening to the recorded sessions and transcribing sessions that included themes relevant to the research question. I then engaged in a process of reading and re-reading the data before beginning noting themes at an exploratory level.
II. Generating initial codes - this was theory driven, with the specific research question in mind.

III. Searching for themes – this involved scanning the transcripts for data related to the research question regarding object relations, sexual intimacy and OCD behaviours. I initially highlighted the relevant sections and noted brief descriptions in the margin.

IV. Reviewing themes - giving equal attention to each data item in order to identify interesting features of the data that formed part of repeated patterns across the data set.

V. Defining and naming themes involved - at this stage I began to organise emergent themes and sub themes into theme clusters with the use of NVIVO 10 to store the highlighted extracts into Nodes and sub-theme folders.

The second level of coding was used to recognise the connected themes and further summarise the data into sub-themes. The structure of the coding was used to start to organise the data around the research question. These structural codes were: Object Relations, Obsessive Behaviours and Sexual Behaviours. The next stage was to consider the validity of the data as suggested by Braun and Clarke (2006 p.21). This involved reviewing the data and developing a thematic map and assessing the accuracy of the map in relation to the clinical data to ensure that the thematic map accurately reflected what was going on in the psychotherapy sessions. As part of the refinement process, consideration was given to assessing how the themes related to each other, and at this point sub-themes were more clearly identified. The value of sub-themes is that they demonstrate a hierarchy of meaning as well as organise what might be thought of as a complex theme. At the end of the process I had a good

understanding of the themes and how they fitted together to highlight the story of the data.

3.9.2 Validation

The interpretive stage of the study inevitably engages the researcher in an active role and influences the study throughout (Smith, 1996), thereby bringing the researcher's own biases to the research process. To guard against this an internal validity of the study was promoted at every stage in the process. I had regular meetings with the clinical and academic supervisors in order to reflect and agree upon emerging themes within the clinical data. As reflexivity is a concept integral to qualitative research (Donnison, Thompson and Turpin, 2009) I discussed the emerging themes and sought feedback about her own thinking processes in relation to the format of the study from her academic peers. I then sought the help of two colleagues working within the Psychological Therapies Team to identify and agree the themes and sub-themes for the study. In the initial coding stage, there was a discrepancy in themes identified. This was due to identifying overarching psychodynamic themes instead of themes more closely related to the narrative. In the second round of coding there was agreement between the three coders. Therefore, in this way triangulation promoted the cross-validation of the study.

3.9.3 Reflexivity

Reflexivity was an important component that was evident from the very beginning of the design stage. This included meeting with the Patient Experience

group who helped me to think about what it would be like for participants in the quantitative strand of the study to be asked such personal questions about their sexual thoughts; their experience of being in the room with me was also thought about with the group. Hollway and Jefferson, (2013, p. 157) highlight:

> 'Reflexivity has opened the way necessary for developments of a research stance that is open to examination (Henwood 2008; Thompson, 2009) because without examining ourselves, we run the risk of letting our unelucidated prejudices dominate our research'.

Hollway and Jefferson, (2013) explore the development of reflexivity including feminist researchers within and beyond Sociology (Stanley and Wise 1993) and Post-Structuralism (Frosh 2010) and point to the importance of Psychoanalytic epistemology which adds to the development of the concept of researcher reflexivity through the use of transference and countertransference phenomena. They cite Hinshelwood (1991 p.255) who reports:

> "Countertransference underwent a remarkable metamorphosis in the 1950's and became an important instrument of research".

During the current study I was aware of my desire to uncover the unconscious dynamics of the obsessional patient. It was therefore important at every stage of the study to review what was being discovered about the participants through their responses and interactions as well as my own countertransference. Hollway and Jefferson, (2013, p. 60) highlight the importance of using one's own subjectivity to

assist the analysis of data. They argue that 'using reflexivity can serve both to guard against bad interpretations and to assist with good ones'.

An in-depth understanding of participants and their experience was highly valued by me and my aim was to maintain an open mind and be open to the participants' experience and not make assumptions about the outcome. In the qualitative study I was aware of the rich clinical data that was coming from the psychotherapy sessions. At times it was a challenge to remain focused on the research question and not wander off into other areas of interest to me. One such area was the dysfunctional relationship between the patient and her daughter, which was a rich source of data but not directly related to the research question. In order to remain focused, I had to regularly review this with my academic supervisor and hold the research question in mind, rather than be sidetracked by the complexity of the clinical material. This process met with the criteria of Hollway and Jefferson (2016) that subjectivity is monitored. The challenge in supervision was always to hold the mind of a researcher and not the mind of a psychotherapist. This was regularly spoken about in the academic supervision meetings.

3.10 Proof Reading

A proofreader was employed from the list available from the University of Essex and the guidelines for proofreading recommended by the university were

followed at all times to ensure the protection and confidentiality of the material contained within this thesis.

Chapter 4 Results: Quantitative Study

4.1 Descriptive Data

4.1.1 Demographic Information.

The demographic data was collected as part of an unvalidated demographic questionnaire of patients attending the Community Mental Health Service. The sample consisted of seven males and nine females. The mean age of the sample was 39 years, ranging from 20 to 64 years, with varying education levels (Table 1). The childhood abuse data identified a significant number of (*n=11)* reported abuse during childhood, *n=7* of those patients reported being the victim of sexual abuse. Reviews of clinical literature and empirical studies report reactions in the victims of sexual abuse to be fear, anxiety, depression, anger and hostility, aggression, and sexually inappropriate behavior. Frequently reported long-term effects include depression and self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency towards re-victimisation, substance abuse, and sexual maladjustment (Browne et al 1986). The experience of a family death in the childhood variable is significant as it may have an impact on the regulation and management of relationships, including separation experiences in adulthood. Of the *sample n=9* experienced the death of a close relative during their childhood years. A full breakdown of the demographic data can be found in Table 1.

Table 1

Demographic Data

Category	Males	Females
Sexuality		
Heterosexual	5	8
Bi-sexual	1	0
Gay	1	0
Preferred not to say	0	1
Marital Status		
Married	4	5
Separated	1	0
Divorced	1	1
Co-habiting	0	0
Single	1	3
Parents Marital Status		
Married	5	7
Separated	1	0
Divorced	1	1
Co-habiting	0	1
Single	0	0
Childhood Abuse		
Sexual,	0	1
Physical	0	1
Psychological	2	1
Sexual and Psychological	1	0
Sexual, Psychological, Physical	2	3
No	2	3
Education Level		
No qualification	0	1
Up to GCSE Level	1	5
Up to A Level	0	1
City and Guilds	1	0
Trade, Technical	2	0
College Qualification	2	0
Bachelors Degree	1	2
Death Experienced in Childhood		
Yes	5	4
No	3	4

4.1.2 Descriptive Data for Independent and Dependent Variables

Obsessive Compulsive Inventory (OCI)

Table 2 below outlines the mean OCI score for each participant. The sample ranged from a total score of 62-159, with a mean score of 109. A total possible score range is from 0-168. This is found by adding together all of the 42 items. A mean score of 2.5 or more in any of the subscales suggests the presence of OCD, but is not

diagnostic. The two highest scores in this study were 56 /mean 3.79 (participant 15) and 137/mean 3.26 (Participant 11). Both of these participants agreed to go on to the second stage, the qualitative study.

Table 2

OCI Score and Descriptives

Participant	OCI	Mean OCI Distress
1	105	2.5
2	125	2.98
3	62	1.48
4	134	3.19
5	74	1.76
6	109	2.6
7	88	2.1
8	117	2.79
9	72	1.71
10	102	2.45
11	137	3.26
12	126	3
13	102	2.43
14	75	1.79
15	159	3.79
16	112	2.67

Sexuality Scale (SS)

The Sexuality Scale (SS; Snell & Papini, 1989) was used to measure three aspects of sexuality within this sample. The higher positive (negative) scores correspond to a greater (less) sexual-esteem, sexual-depression, and sexual preoccupation. The subscale ranges were: sexual-esteem = -20 to 20; sexual-depression = -16 to 16; and sexual pre-occupation = -20 to 20. The sexual esteem questions measured positive regard for and confidence in the capacity to experience one's sexuality in a satisfying and enjoyable way. Participants (*n=13)* reported a negative sexual esteem, with an average score of -8.875. Sexual depression is defined as the experience of feelings of sadness, unhappiness, and depression regarding one's

sex life. The analysis of the data found that sexual depression was present within the sample, but was the least problematic of the three areas assessed with an average score of 4.0625.

Sexual preoccupation is defined as a tendency to think about sex to an excessive degree. Analysis of the data found that *n=12* participants had a negative preoccupation with sex. The average score was -8. This suggests that the sample ranged from a moderate to strong level of lack of interest in sex. There were *n=4* male participants who rated highly in sexual preoccupation. This confirmed findings (Snell & Papini, 1989) that men reported higher levels of sexual preoccupation than women did. There appears to be no gender differences in the other two categories of sexual esteem and sexual depression. Table 3 gives a breakdown of the individual scores. Table 4 indicates the individual participant total scores for the Sexuality Scale Questionnaire.

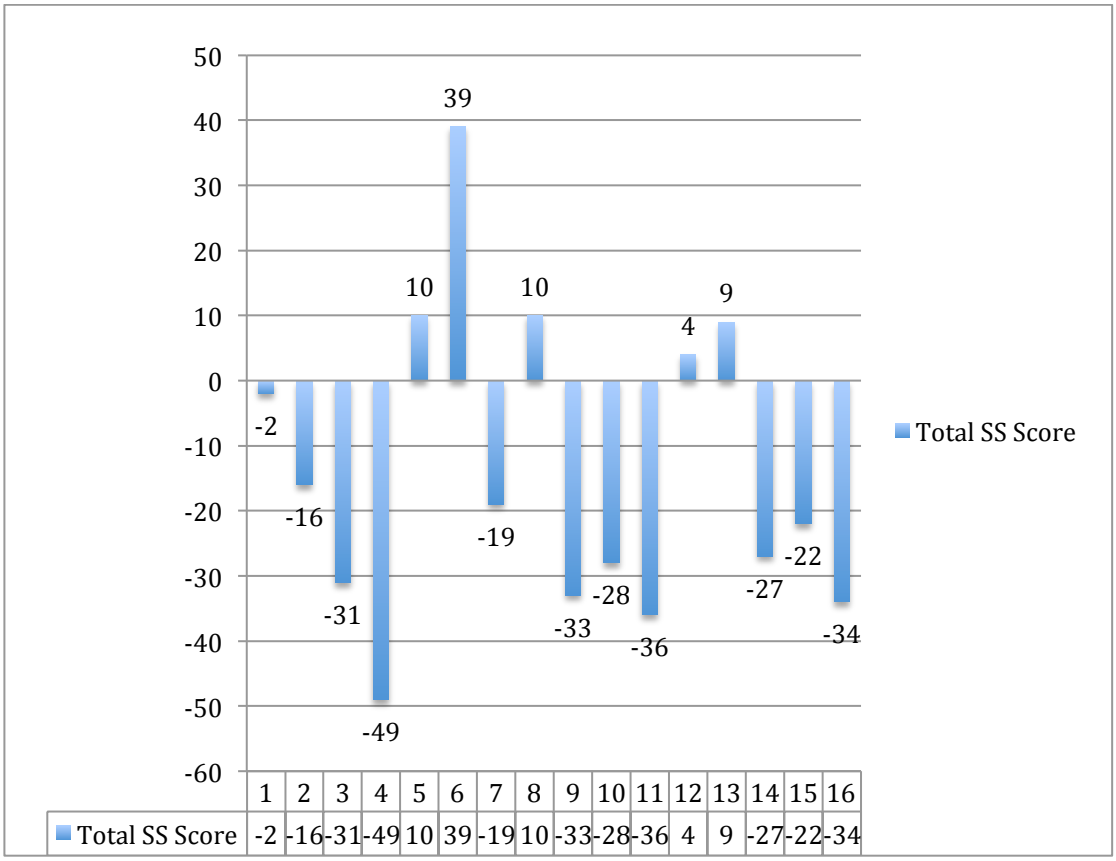
Table 3

Sexuality Scale (SS) Descriptives Breakdown

Participant	Sexual Depression	Sexual Esteem	Sexual Pre-occupation	Q 11 & Q14 Included in total
1	3	3	-8	-2
2	8	-12	-8	-16
3	-3	-7	-19	-31
4	-5	-20	-20	-49
5	7	-5	9	10
6	4	15	20	39
7	12	-16	-16	-19
8	14	-20	14	10
9	2	-16	-19	-33
10	9	-20	-16	-28
11	-1	-12	-19	-36
12	-2	11	-8	4
13	9	-9	9	9
14	-2	-4	-19	-27
15	1	-11	-8	-22
16	9	-19	-20	-34

Table 4

Individual Total Sexuality Scale Results



4.2 Results

The data from the questionnaires report was as expected, which is that patients with high levels of OCD have difficulties in their sexual functioning. The Spearman's rank order correlation (rho) was run as it is particularly useful to test for a rank order relationship between two ordinal variables where the sample size is small. An assessment of the Spearman's rho correlation revealed non-significant correlation between sexuality scale and OCD r=0.044. There is no statistical significance of the findings as the data is not meeting the threshold of statistical significance, p>0.05.

Table 5

The Spearman's rank order correlation (rho)

Spearman's rank order correlation			S.Scale	OCD
	SScale	Correlation Coefficient	1.000	.044
		Sig. (2-tailed)	.	.871
		N	16	16
	OCD	Correlation Coefficient	.044	1.000
		Sig. (2-tailed)	.871	.
		N	16	16

4.3 Discussion

The questionnaires provided in-depth data of OCD and sexual perceptions of the participants. The Spearman's rho test did not pick up a statistically significant correlation between the two categories under examination. The main reason for this is likely to be the small sample size, although the ability of the questionnaires to pick up the relationship between the variables is limited, when breaking down the sub-scores a greater significance can be identified. It is recognised within the field of research that a much larger sample size is required in order to prove a statistical significance. This does not mean that there is not a correlation; it simply means that this study has not evidenced it statistically. The significance of 0.044 would suggest that a much greater sample is likely to yield a significant correlation. A consideration for any future study would be to recruit a much greater sample size to increase the possibility of evidencing a statistical correlation.

The value of a mixed method of study is that the quantitative data evidences the existence and depth of the problem, which will add to the reliability of clinical observations in the second stage of this study.

4.4 Limitations

A limitation of this study relates to the brief time frame allowed to complete the structured interviews. Furthermore, the use of just one location significantly reduced access to patients who may have been suitable for the study. An inherent limitation is the impossibility to compare the probable detrimental effect of disorder duration on sexual functions due to the cross-sectional nature of this study, limiting its ability to demonstrate a relationship between sexual dysfunction and OCD. The limitation of using self-reporting questionnaires to measure unconscious processes is also worthy of consideration. The absence of directly comparable studies makes it difficult to establish the validity of the findings of this study.

4.5 Conclusion

Sexual dysfunction can be evidenced within the OCD population of this study but it has not been possible to prove a significant correlation between problems with sexual intimacy and OCD. The research sub-question ‘What is the nature of the sexual difficulty, as categorised in the quantitative study’ has now been answered. The most problematic sexual perceptions were identified as negative ‘sexual esteem’ and negative ‘sexual pre-occupation’.

A more qualitative in-depth case study was required as recommended in previous studies (Hinshelwood, 2013; Leuzinger-Bohleber & Fischmann, 2006; Mills (Ed), 2004; Giannoni, M., 2003) in order to test knowledge and the study hypothesis.

It was determined that a single case study using the psychoanalytic concepts and Klein's Object Relation framework would enable access to unconscious processes to locate the origins of distress. As I moved into the second stage of the study my task was to see if the case study would provide information to explain the sexual difficulties identified above and help me to uncover the nature of the object relations that may have prompted such debilitating OCD behaviours found in the quantitative study.

Chapter 5 Results: Clinical Data

This chapter reports on the results from the clinical data. It begins by describing the study design and goes on to present the clinical data.

5.1 Introduction

The study design consists of the setting, the research question and the clinical data. The setting involved setting out a contract for the analytic frame, which was highly controlled, utilising the techniques of free association, interpretation and countertransference. The conditions included sessions being offered on the same day and time each week, with the boundary of the analytic hour, being maintained. This met with the conditions for maintaining the rigour of investigation as the natural science model (Hinshelwood 2013). The research questions related to the case study were:

1. What is the connection between Object Relations, problems with sexual intimacy and Obsessive Compulsive Disorder?

   Subsidiary questions:

   iii) Are sexual difficulties identified in the findings of the quantitative study explained in the findings of the qualitative study?

   iv) How does the patient in the single case study speak about her object relationships and what is the connection to OCD?

2. What are the implications for the treatment of OCD in the NHS?

The logic for the research question was to provide a definitive answer to the research hypothesis which was that 'Klein's account of obsessional neurosis as resulting from projection of disowned and hated figures (part-objects) into others, who are then experienced as hating and persecuting figures and have to be warded off with obsessional rituals, is relevant to understanding the sexual problems of OCD patients'.

The clinical data is based on a brief psychotherapy of 32 sessions within an NHS setting. Of the 32 sessions, nine sessions contained data relevant to the research question, and the themes have been extracted from transcripts of those psychotherapy sessions. The content of the sessions that were not used was predominantly related to the management of the dysfunctional relationship with her daughter and Julie's inability to manage any close connection with her, along with the exploration of an extreme presentation of OCD triggered by the possibility of any form of interaction with others. The clinical material evidenced the constant attempts by Julie and her daughter to entrap the paternal family in their cycle of distress. Whilst this provides powerful evidence for the quality of Julie's relating to her children and significant others, it does not contain clinical data relevant to this study, but will be used in future studies and academic papers.

The presentation of clinical data will be in chronological order following the emerging themes identified during the thematic analysis. The clinical data will be presented under the following headings:

1. The patient's history
2. Nodal maps and thematic coding
3. The identification of themes as they developed throughout the psychotherapy treatment in relation to object relations, obsessional behaviours and sexual behaviours.

5.2 The Patient's History

Julie is a 43-year-old woman who was referred to Secondary Care Psychological Therapy after two previous treatments with CBT provided little improvement to her everyday functioning.

Julie was brought up by a mother who, according to Julie, "*had her own problems and did not really know how to be a mother*". Julie framed this within a context of her mother becoming a mother in her mid-adolescence. As a child Julie had very limited contact with her father as he left before Julie was four years old and only remembered him coming into her life briefly when she was nine years old before breaking off contact again a short time later. Julie had four older siblings; her two brothers both displayed delinquent characteristics. Julie's older sisters both had different fathers and Julie grew up thinking her older sister was her aunt. From a young age Julie developed something of a parentified child position and regularly returned home from school at lunchtime from primary school years onwards to check on mother. It seems that from early on Julie had an awareness that mother was fragile and needed looking after. There was no recognition of her own fragility. Julie

developed OCD checking rituals in early adolescence and began to display anorexic tendencies around the same time.

When Julie was thirteen years old her older brother Jeff raped her whilst her mother was out drinking with friends. She described both of her brothers as emotionally and physically abusive towards her. On one occasion they set a fire in the family home whilst mother was out. Subsequently, Julie has an abiding memory of sitting on the stairs looking out of the landing window onto a dark street, waiting for mother to return. At the age of fifteen years old Julie was diagnosed with Anorexia Nervosa and was treated in hospital for the condition. She has no memory of her mother showing any concern about her weight loss. Julie told me that she has "*always felt anxious*".

As a child, Julie was aware that people called her mother "a Jezebel" but didn't really understand why, even as an adult Julie never really understood it, as she "*never saw her mother with men*". Julie's own relationship history was complicated. At the point she entered psychotherapy she had not dated for ten years. In addition to OCD rituals, Julie had an obvious nervous tic involving involuntary movements and a stammer.

5.3 Nodal Maps and Thematic Codes Identified

The analysis of nine transcripts of psychotherapy sessions resulted in the emergence of three title themes related to the research question being identified. The nodal maps can be found below in Figure 2 below.

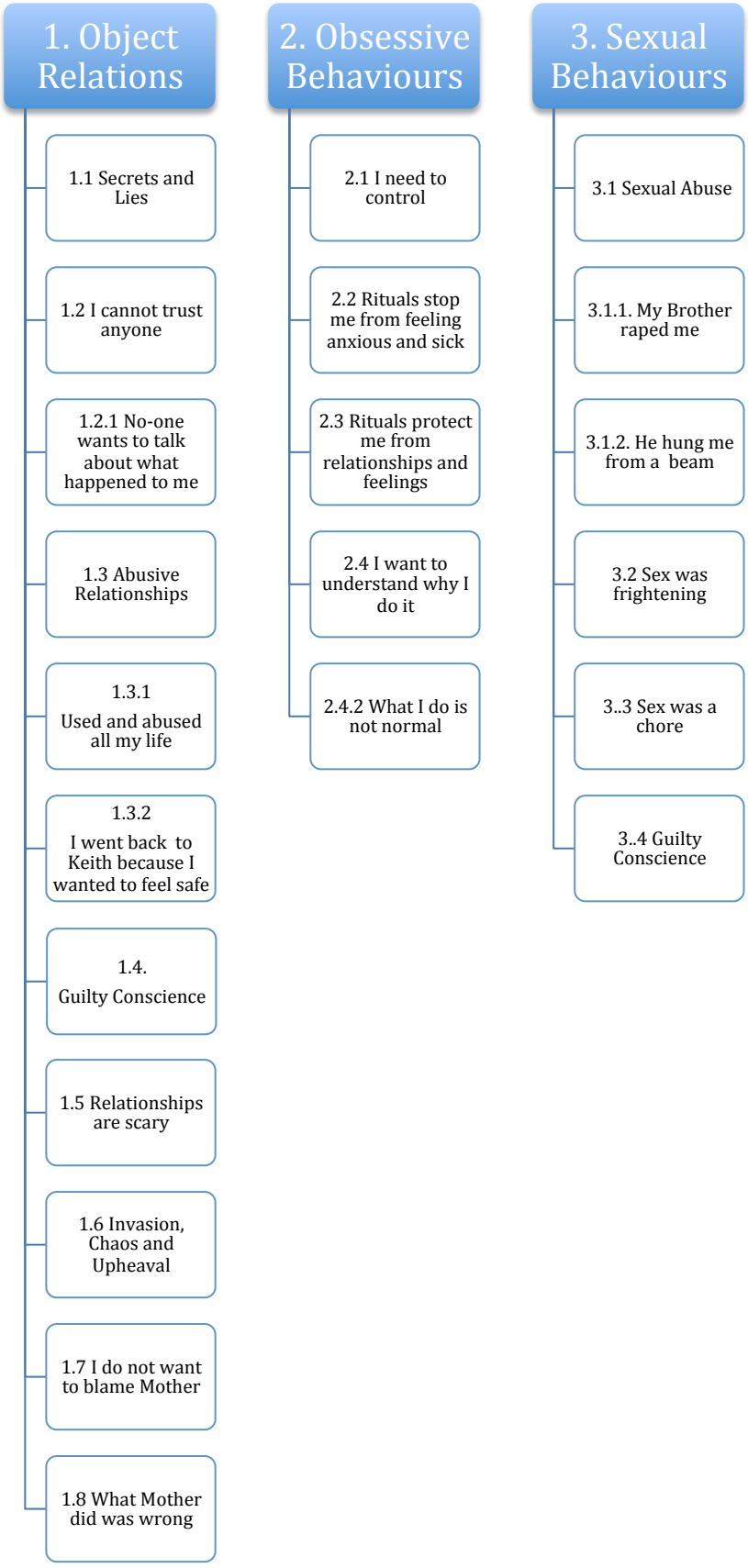


Figure 2 *Nodal Map*

5.4 Session Content

The study will be conducted using Hinshelwood's (2013) Research on the Couch model, which will be used to test the validity of the study hypothesis.

The unique value of psychoanalytic research is the significant role of transference and countertransference material, as together with clinical evidence they allow for the material to be considered from two different positions. This process is known as triangulation (Franke, 2006; Hinshelwood, 2013). Countertransference relates to the feelings that the analyst experiences towards the patient and is understood to offer additional information that is defended against by the patient. Heimann suggests that:

"The analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious". (1950, p. 81)

Hinshelwood (2013 p. 118) tells us that whenever the psychotherapist intervenes in a session by making an interpretation, an effect to the interpretation is expected. My interest was to see if this could be evidenced through the identification of a confirming effect to any interpretations that I made. Hinshelwood (2013 p.119) describes this as resembling what happens in a laboratory setting where the interpretation would be the experiment and the results would be its effects:

> "*So we are looking for occurrences, with an inferred meaning (giving rise to a metapsychology-rich interpretation), and how the associations subsequent to the interpretation reveal an occurrence demonstrating the interpretation's effect". (*Hinshelwood 2013 p.119)

The other important consideration is the metapsychological meaning of the unconscious material, which, through the use of transference and countertransference can be brought into conscious awareness. Hinshelwood tells us that:

*"We gauge the effect of an interpretation, by changes in transference, the transference-countertransference relationship, resistance (and inhibition) or its reduction" (*Hinshelwood 2013 p.119).

In this study I sought to formulate interpretations and to observe the effects. Hinshelwood describes this as being '*in the realms of hermeneutics*".

The analysis of the data began with Session 2 where two of the main themes, Object Relations and Sexual Behaviours, emerged.

Session 2

Julie began the session by talking about her car key fob not working and elaborated on the complex obsessional thinking that followed the discovery. Julie noticed this just before leaving for the psychotherapy session and this added to her

normal level of distress about leaving the safety of her home. Julie felt that she was being stopped from seeing me. What follows is an attempt to bring out into the conscious mind what the key fob represented in her unconscious mind. This process begins with Julie recognising that the obsessive behaviours support the need to be in control of her environment. I ask about other situations where she has felt fobbed off. This opens up the first sub-theme, 1.1 Secrets and Lies, within Theme 1 Object Relations:

Sub-theme 1.1 Secrets and Lies

J: (silence 6 secs) There have been loads of them hasn't there really um.

T: What comes to your mind now?

J: I've got a c. c. c. couple I've got my husband (Keith) in my head I've got my brother (Jeff) in my head.

T: Which brother?

J: P P P Jeff. I've got work but yeah, not knowing what was going on all the time. Although I knew what was going on with my brother (Jeff) I just ….I think it's the secrecy as well isn't it.

T: Secrets say some more about that.

J: (Sniff) Obviously being told not to say anything to anybody and….

T: Don't tell anyone about what he did to you.

J: (Sniff), um, so I guess that's I don't know I don't know I'm trying to put it all together in my head myself. (08/12/2015 P4 L185-207)

In this communication Julie tells me that in her mind her husband Keith and her brother Jeff are in the same category. Both of these relationships were dominated by secrets and lies. My response to this communication was to feel tension in my body, which I understood to be a countertransference response. I then made a transference – countertransference interpretation suggesting that perhaps she worried that I too might fob her off and want to get rid of her. Julie attempts to deny the interpretation, but then concedes that it may be possible, after all, she says, she doesn't know me. My countertransference tells me that Julie is extremely fragile and I will have to tread carefully. This is an example of the change sequence as described by Hinshelwood (2013, p119) whereby the meaning occurrence which at this point is unconscious is brought into consciousness by the interpretation and the causal occurrence emerges. The accuracy of the interpretation is confirmed as Julie makes further connections to her object relations and the next sub-theme is identified:

Sub-theme 1.2: I cannot trust anyone

J: By people (T: Yeah) I I (clears throat) I do have a very very big trust issue with people. ..... Yeah it is it is it is everything has to be in black and white that's the thing. Everything has to be has to be I have to have it. It's like everything has to be filed away in a box in the right order (getting bottle of water out of bag) otherwise it's not (taking sip) concrete. It's not set in stone it's not (T: Set in stone) oh (big sigh). (08/12/2015 P5 L223-236)

Julie is describing the defensive position she has adopted in order to protect herself within her relationships. All interactions with them have to be in a controlled and concrete manner, much like her OCD behaviours. As the therapy continues Julie gives an explanation for why she has adopted such a rigid strategy and a sub-theme in Theme 3. Sexual Behaviours emerges:

Sub-theme 3.1.1 Brother raped me

J: I can see now I can see him I think I said to you just before I was in the box room (addressing tick of shaking back her shoulder pushing movement with hand and arm – "oh stop it") (Silence 12sec) I can see me laying on the bed (crying, sniff) hold on (silence 5sec clears throat) (crying 17sec) I never got to tell anyone did I until it was all too late (cries)… …… I can see me and I can see me in that room on that bed (T: a hum) but I can see him oh it's horrible it's horrible remembering it because (sniff) it brings it all back. Oh (clears throat). (08/12/2015 P5 L241-256)

Julie describes a traumatic scene of herself as a child lying on the bed, alone with her horrible memories of the rape, which she kept secret for almost 30 years. The countertransference response is of a sinking feeling of what happens when Julie is left alone. I wondered with her if she feels that I will leave her alone with these memories at the end of the session. I held onto it, expecting to find an opportunity to bring it into the session. Julie's response is to describe how she feels alone with the trauma of what happened, a further sub-theme related to Theme 1 Object Relations is revealed:

Sub-theme 1.2.1 No-one wants to talk about what happened to me

J: *It's the visualisation ah you know if I 'cos obviously it's there a lot of things are there in the back of my head. If I let it come to the forefront I can't talk to anyone else about it. Because Malcolm (second brother) doesn't deal with it. Karen (sister-in-law) doesn't deal with it even though they she knew. Mark (son) thinks my brother's the biggest [(gestures] beep beep) for what he did so he doesn't want to talk about it. In fact he won't even talk about Claire (daughter) no more, not nothing. (Clears throat) Um so it's like nobody wants to talk about it. You are the only person that will talk about it. (08/12/2015 P6L269-276)*

I return to the theme of being fobbed off and make a transference connection by saying that perhaps Julie fears that I will not believe her either, that she will be left alone again with these terrible memories. Julie side steps my comment and reports that the long held secret of the rape is now known about and family members are unwilling to talk with Julie about it. Julie suggests this has added to her "very big trust issues". This information tells us that the family splits off from difficult issues and avoids dealing with them. The final sentence in this section "you are the only one who will talk about it" gives meaning to why it was so important for Julie to attend the session and why she was so distressed that the key fob to her car was not working. Julie needed to have an experience of an object, in me the psychotherapist, who could allow her to speak about the rape and join empathically with her, validating her distress. She continues with the same theme:

J: *I am scared to talk to them about it now…. It's been over a year… it frightens me because I needing people to talk eventually about these other issues that probably haven't happened yet and I'm frightened to talk now to talk to these people that are close to me that I feel I can't trust them. Because I can't trust them with anything that I will talk to them about because it frightens me and they're not gonna want to know or that they're not gonna believe. (08/12/2015 P8 L340-345)*

I summarise by saying that Julie is unable to talk about frightening things because the idea of being rejected is as frightening as the abuse. Her object relations are fraught with fear and she cannot trust anyone, including me. I suggest that if she carries this template into her intimate relationships, it is easy to understand why a sexual relationship that involves the surrender of control might be so difficult for her and why she avoids connection through her OCD.

The above clinical data meets with Hinshelwood's (2013) conditions where he reports that where the interpretations are accurate, further unconscious material is revealed.

Session 5

Julie begins the session by saying "You look lovely today Beverley". My countertransference response is to feel wrong footed and uncomfortable but could not

discern exactly why. I simply smile and say thank you and hold on to the information. She goes on to say that her mother always wanted the best for her. As the narrative evolves, the communication changes and Julie gradually identifies that she has probably been abused all her life and sees the OCD behaviours as a way of controlling her environment and the proximity of others. The presence of the stutter suggests high levels of anxiety. I then understood more about the opening remark and feedback my countertransference information by saying that perhaps there is a fear that I will change from being a lovely mother to being an abusive mother.

The interpretation is confirmed with the metapsychological meaning of the unconscious material, which, through the use of transference and countertransference is brought into conscious awareness. Changes in the transference-countertransference relationship become evident and there is a reduction in resistance.

A subordinate theme of Sub-theme 1.3 Abusive Relationships then emerges within the Theme 1. Object Relations:

Sub Theme 1.3.1 Used and abused all my life

J: I di di di di do do do feel like a lot of people have p p p p p played with my emotions.

T: Including your mother?

J: Um…. Mum always wanted best for me… I loved her I still love her to pieces. In, in, in, in oh… in a roundabout way I could be scared of her as well. (06/01/2016 P1 L38-43)

The fear that Julie felt towards her mother is revealed. Julie then describes an occasion when mother had sent her brother Malcolm to fetch her home from play and he dragged her home by her hair. It is significant that Julie is unable to question the actions of her mother, who likely knew that Malcolm would not deal with her gently as he had a pattern of physical violence towards Julie. The Sub-theme 1.3.1 Used and abused all my life within her object relations continues:

J: Because of my brothers NOT that they didn't protect me 'cos they did protect me when I was in the house on my own when she (mother) was up in London. There was still bad behaviour. You don't say well done and pat them on the back when they punch somebody… So I feel I've been used and probably abused all my life really and all I wanted to do was protect people (crying) and the only way I can do that is to be by myself and do all the things I do indoors.

(06/01/2016P2L89-96)

This highlights the confusion that Julie feels between the good and bad object positions, with brothers that protect and brothers that abuse. It is further evidence of mothers' lack of care or concern. Julie was left with her delinquent brothers whilst she went away for the weekend. I deduce that Julie is making an unconscious connection to her mother when she reports that she has probably been used and abused all her life. The connection is made by the words "*and all wanted to do was protect people*". I knew from earlier sessions that Julie has always been concerned about the protection of mother. Julie makes a connection between the OCD rituals and her object relations. I wonder if the unconscious communication is a reference to protecting others from

her hostile feelings. This provides important metapsychological meaning to be used later. As the session progresses Julie begins to think about the function of her OCD behaviours and first sub-theme within Theme 2 Obsessional Behaviours emerges:

2.1 Rituals stop me feeling anxious and sick

J: *(Crying) As I said to you before if I don't do them things go wrong but they go wrong anyway. So I have to do it. Over the Christmas period Mark (son) tidied his wardrobe and didn't put things back in the right way and I had to take them all out and do it again you know put the hangers around the right way. Mark said to be " blimey mum you've got this bad haven't you". Um but he let me do it.*

T: *And if he hadn't let you.*

J: *I can't. Again I've got that overwhelming feeling of being anxious and sick. I tried to walk away ... because he put them all the wrong way ... and I changed them all around. He told Joyce (his Grandmother) and she said "that's really bad" but its not for me, because it made me feel better that it was that they were the right way… it's crazy but if I don't do it I know I would be thinking about it. That's why I have to go back and do it.*

T: *The wrong way around represents something for you, doesn't it. If the hangers are all the right way around, you feel calm…. But the anxiety is really about something else ... in that moment the anxious feelings are all projected onto the hangers and everything being in the cupboard as it should be, and then you feel calmer, no longer agitated or sick. I am thinking about the relationship with*

mum; usually it is a mother's role to care and worry about her child and yet you have told me a lot about how much you worried about mum and how she did not seem to worry about you. It is also wrong that a bother would rape his young sister, or terrify her with his words.

J: I always worried about her (mother) even when she died.

(06/01/2016 P3 L100-121)

This is an example of the change sequence as described by Hinshelwood (2013, p119) whereby the meaning occurrence which at this point is unconscious is brought into consciousness by the interpretation and the causal occurrence emerges. Julie confirms my interpretation of the connection between the obsessive behaviours and her internal object relations. The task for Julie is unrelenting. She cannot acknowledge the intensity of the abandonment that she experienced and instead demonstrates how she protects mother from the unconscious hatred, even after her death.

Session 7

In Session 7 Julie give us further evidence of her destructive relationships by returning to the theme of abusive relationships. For the first time Julie speaks about a lesbian relationship. The third sub-theme in Theme 1 Object Relations is identified:

Sub-theme 1.3 Abusive Relationships

J: My last relationship was obviously with Keith (husband) and I got the divorce and I had this, this, sort of relationship with this, this, um woman. ….. I guess I feel slightly embarrassed because of putting my family through it because they found out. (T: Your children) They used to call me you know sort of silly names you get called when you become come in a relationship with a woman

T: Who called you names?

J: My brother (Malcolm) (tearful) I don't want to repeat it (crying, sniffing) so yeah. It's horrible (crying) … in fact even to this day he still reminds me and I laugh about it. But I'm not laughing about it 'cos he says it in front of people.

T: What does he say?

J: (Crying 12 sec) It does stay here for you doesn't it (sniffing 10 sec crying)… he says it in front of people people laughing and I don't laugh he says to me "remember when you used to be a rug muncher" (T: Oh) crying… (head down) "never thought we'd see our intelligent sister you know doing things like that." He hasn't yet he can laugh about things like that but you can't take on board what happened with my other brother (Jeff) (crying) … surely that's more worse than that (crying 10sec). Oh crikey... then he never lets me forget. He said it in front of some random person …… "Julie this is Paul he's doing our flooring for us" and he went 'Oh Paul this is my sister Julie the rug muncher" (T: Oh) so he gets himself you know out of it but he thinks it's funny he's got this way hasn't he of yes he's got this way of making people feel small and intimidation as well. (19/01/16 P9L425-515)

This material is evidence that the emotional abuse that Julie received from her brother Malcolm as a child continued into her adult life. Julie is able to recognise that he uses humour to mask his aggression towards her. My countertransference response is to feel sickened by the perverse nature of Malcolm's communication and I felt a strong desire to offer care. I also began to understand why Julie is attracted to those who 'appear to be able to protect her'. Julie goes on to explain her actions as if responding to Malcolm. I wondered if she felt the need to explain it to me too, and my mind returned to the sequence in the previous session about 'things being the right way around". I wondered if she was trying to communicate something about her lesbian experience as well as the natural expectation that family protect rather than damage. Initially the relationship with Martine was "something different exciting" … "she had just come out of the army, she was butch and similar to Keith" but that it quickly turned abusive. As the material unfolds Sub-theme 1.3 of Abusive Relationships continues:

Sub-theme 1.3 Abusive Relationships

J: *I was trying to think about e e bl bl bl b bl everythink that we talked about last week here on the Tuesday when I left here. ….. So yeah so that relationship was um, pr pr pr pretty abusive. She actually stripped naked in my front room once, with a chap there. There was nothing you could do about it she was just so strong willed. She never had qualms any qualms about she never had any qualms or any confidence issues about being who she was or showing her body or anything like that.*

T: *And you were in a relationship with this woman.*

J: Yeah and she did this in front of a man and this man actually said and I knew him. He um t he he he used to be um in the door security yeah (T: Um, um) bouncer thing. And I I knew him and h he actually said to her "put your, put your clothes on you're embarrassing yourself". And this was one evening when she came home from work and he dropped her off brought her um 'cos she stayed at mine quite a few times. Only when the kids weren't there (intake of breath). So so you know she did actually get to know the kids but she did you know…. Yeah …… it was horrid that was horrible as well. See it feels so it was at th th th that at that point that I I I um, 'cos she obviously d r she must have been drunk herself to have done something like that but she would have done that anyway. She had no qualms she had no self no self-confidence issues. She was a very confident person…that's another thing my brother used to say "who'd be the woman who'd be the man". You know, things like that things that just it's just… Taking into consideration he's 3yrs older than me my brother (Malcolm) you know. Why (sigh).

(19/01/16 P11L530-559)

This segment provides further evidence of abusive relationships and the humiliation that Julie suffered. There is a connection to the third theme Sexual Behaviours as Julie is describing being sexually humiliated by her partner Martine. The return of stammer is evidence of high levels of anxiety connected to relationships. I notice a sense of shame related to the lesbian relationship and connects it to the obsessional behaviours, which are employed to control the space around her and ward of anyone who might try to get close to her. I make a transference interpretation by

saying ‘ it seems to me that you worry that I too might humiliate you in some way’. This leads to new insight coming into her conscious mind and the third theme in Theme 2. Obsessive Behaviours emerges:

Sub-theme 2.3 Rituals protect me from relationships and feelings

J: (5sec) (voice breaking) my feelings, does the OCD control my feelings, it stopped me getting into a relationship ever since (crying).
(19/01/16 P13L592-593)

Here I observed Julie making the connection between abusive relationships and obsessional behaviours. So far Julie has told me that she is repeating patterns in her choice of partners. In Session 2 she named her husband (Keith) and brother (Jeff) as being abusive towards her. In Session 5 Julie told me that her brother Malcolm had been physically abusive towards her, and now in Session 7 Julie describes how both Martine and Malcolm were emotionally abusive. Julie is also beginning to recognise that the function of the OCD is to control unbearable, anxiety provoking feelings such as shame, guilt and anger. At an unconscious level, OCD serves as a defence against unbearable feelings that prevent her from establishing another relationship by warding off anyone who might attempt to get in close proximity to her. In this material a connection between Object Relations, Sexual Intimacy and OCD is becoming evident. The concept of shame is also introduced. Julie begins by suggesting that she was “*sort of embarrassed*”, of putting her family through her tumultuous lesbian relationship that was characterised by Martine’s observable promiscuous sexual behaviours with men and women.

Session 8

Upon entering the consulting room Julie returns to a previous comment:

"You look lovely today, well you always look lovely…I'm hardly likely to come out and say, "Beverley you always look horrible" (laughs). That's horrid out there. Really, really, really, really windy." (26/01/16P1L1-4)

I notice that she is rocking backwards and forwards. Julie appears disconnected and I ask her what is happening. She appears to struggle with a response and so I wonder aloud what the opening remark meant. I suggest that perhaps it conveys something of a loving and hating that she feels towards those that she is close to. Julie returns to the theme of relationships.

J: *I'm ashamed of myself for feeling how I'm feeling but I do feel like (oh here we go) and I keep coming light headed again still like I was last week. Because he's my son I just feel I shouldn't be thinking like that, I shouldn't be thinking like that but I am, I'm thinking like. .... Sometimes I think like when I'm sitting there and I think I don't want you to come home tonight or, not in a bad way but know he's got to come home so um I just feel oh God he's in my way. You know I can't do all the things that I want to do. (26/01/16P1L29-32)*

This is a reference to her OCD checking behaviours, which often place her in dangerous situations late at night when she is checking her car which causes great

distress to her son, who polices her behaviours in order to keep her safe. This is another example of a change occurrence, where the transference interpretation sheds light on the hidden meaning. The light-headedness suggests a somatisation of the anxiety as she becomes aware of the nature of her difficulty. It is also possible now to predict that her anxiety involving object relations is far reaching. She laments that she would like to have a relationship where she would be looked after. The second sub-theme in Theme 1. Object Relations develops:

Sub-theme 1.2 I cannot trust anyone

J: (Deep sighs and deep breaths). I think I've said before I would like to have a relationship. I'd like to be looked after but I can't help thinking it's too late now ……. Because of all my trust issues and because of not going out, you know (deep breaths)

T: So when you think about being in a relationship the overwhelming sense is that you cannot trust the other person. Relationships are not safe.

J: Being let down again. Being let down and… you see I've probably contradicted myself here because I said I want to be looked after but just then the thought that came into my head is that I want to be in control and I need to know and I want to be in control. WHY? Because I've been on my own for so long and because I'm in that house and I have my own ways of doing stuff that you're aware of for someone to c c c c come back in again into that that would be messing it all up and that's scary for me. (26/01/16 P4L113-123)

I make an interpretation bringing together previous information that had been discovered by saying that Julie's OCD rituals represent a need for everything to be ordered in contrast to having no control in her abusive relationships. Julie makes an immediate connection with sexual relationships:

J: Well... oh crikey I haven't had sexual relationships for a long time so that would be…. I know a relationship isn't based just on the physical side of it but that would scare the life out of me anyway. (26/01/16 P4L127-129)

In the above sequence, Julie recognises that what she longs to be looked after, but because of past experiences she cannot trust anyone. At this point the intensity of her fear of intimacy is revealed. As the session progresses, Julie further develops the connection between Object Relations, Sexual Intimacy and OCD. As Julie describes the mismatch of libido in previous heterosexual relationships the second sub-theme in Theme 3. Sexual Behaviours is recognised:

Sub-theme 3.2 Sex was frightening

J: Yeah. All of them have. That sounds awful Peter, Danny and Keith. I don't know if it's a man thing but they've all had high sex drive. I never have I know I haven't I'd would probably have to be oh crikey maybe have a drink to calm or to have courage. I don't know but I never instigated and I can never remember

instigating anything like that so yeah that would be really frightening for me as well as the being out of control in their house.

T: Thinking about a sexual relationship is frightening. I wonder what is so scary.

J: It's that really getting close isn't it? Really getting close again

T: Anything else?

J: I can't I just can't t t t t thought of penetrative sex at the moment. It just horrifies me.

T: Someone being inside you.

J: Hurt being hurt

T: Being hurt physically or emotionally.

J: Physically and emotionally

(26/01/16 P5L137-150)

My countertransference was to feel tense with my heart beating fast. My initial thought was that this feeling related to the rape, but quickly learnt that it related to being close physically and emotionally.

Julie reveals that sex is frightening, being out of control is frightening (at this stage I did not know what being out of control meant*)* and that she needed alcohol *'to calm her' and 'give her courage'* in order to proceed with the sexual act. Julie goes on to describe how she connects penetrative sex with being forced physically and emotionally. This connects the sexual relationship to the quality of her object relations and we learnt in the previous session that OCD serves as a guard against relationships. So, the unconscious nature of her object relations and the attempts that she makes to

protect herself from them are gradually being revealed. This again meets with the conditions for what Hinshelwood (2013) describes as a meaning occurrence. In this situation we have evidence of the split between sex life, her fear of someone being close physically and emotionally and fear of being out of control. This leads to a further sub-theme in the Theme 3. Sexual Behaviours being recognised:

Sub-theme 3.2.1 Sex was a chore

J: Maybe it's because as long as I can remember I've never had a very high sex drive I could take it or leave it but erm but with those long relationships that I had with Peter d d d d Danny and K K Keith I can always remember that the physical contact the sex side was a very very high priority. I probably found it probably more of a chore.

T: You didn't enjoy it.

J: No I don't think so no. But if I the only time I did I guess if I can think about this properly now is with Danny and then once we had the kids you know obviously after Mark was b b born that was erm that was it but I guess it was the oh how can I put it without sounding awful (6 sec pause) it just felt it felt at that time right with Danny.

T: Something about the connection and feeling safe.

J: Yeah. Just because he had at that time I don't how now if now would be the case but to me he ticked at that time until he said to me about having an abortion with Claire (daughter) but at that time he ticked all the right boxes. He made me laugh he and was caring.

(26/01/16 P5L156-171))

I learn from this segment that when someone ticks all the boxes and becomes the good object, Julie can feel safe and can enjoy sexual relationship. However in reality the good object quickly turned into a bad object, who wanted her to destroy what they had made together.

After a short deviation Julie returns to the affair that she had with Danny and described it as a time when she felt connected and resulted in her giving birth to a daughter. The sub-theme that emerges from this material relates to the two themes of Object Relations and Sexual Behaviours:

Sub-theme 1.4 and 3.3 Guilty Conscience

J: I had a guilty conscience. I know I've got a guilty conscience. I know and to me that was a big a big it shouldn't have happened. I should have looking in hindsight I should have come out and said something. I should have I had doubts because I wasn't sure was I. I had doubts oh God.
(26/01/16 P12L 398-401)

Julie initially denies that she continued to have a sexual relationship with Peter (her partner) whilst she was having an affair with Danny, but then admits it.

J: Because obviously I did I wasn't not not constantly but there were occasions again this is coming back for it to being like a chore that side of it because obviously he (Peter) had needs. Obviously in the back of my head I knew I was

doing wrong by seeing Danny so I had to give him some kind of time sexually so there's the doubts. Otherwise I could say I didn't have sex with him at all whilst I was with Danny but that's not true because obviously I did because of his needs. But it wasn't as frequent as it used to be which wasn't like I said really frequent in that you know.

T: So being intimate with Peter while you were having a relationship with Danny meant that you could, if you like, hide the affair in some way or pretend.

J: Just to keep just to keep just to keep him happy. To make him not notice that I was seeing Danny it sounds awful SO blooming awful. So there's my eliminate of the doubt because alright I'd been with Peter for a number of years. Yeah we'd split up and we got back together but there was never any scares of being pregnant but never any scares at all. Erm so in the back of my mind I know I should have been thinking well it hasn't happened before so it can't possibly be his but there was that element of doubt that you think what if it is. You know after after after having her should have made me do a DNA test but I don't know I don't know what was going through my head at that time. I reckon I've always been a messed up kid poor kid. Messed up kid into a messed up adult.

T: Where did that come from?

J: (10 second pause). I don't know (12 pause) such a dysfunctional family. We were such a dysfunction family. We still are such a dysfunctional family.

(26/01/16 P12L405-425)

This segment helps me to understand the earlier comment related to being forced to have sex. It seems that she is referring in this instance to having to have sex with her first partner (Peter) in order to hide the affair with Danny. Julie expresses

guilt for her devious behaviour and the lies that she told in order to hide the affair, as well as hiding the fact that Danny is Claire's biological father.

The comment "*messed up kid into messed up adult*" suggests that Julie recognises that she has always had difficulties in her object relations and this can be traced back to her childhood. Interestingly, Julie uses the word 'eliminate' instead of 'element' in reference to doubt. This was not picked up in the session at the time but provides an interesting link to her statement about being a "*dysfunctional family*". The connection is that Julie repeated the behaviour of her mother who hid the parentage of her two older daughters by identifying Julie's older sister as her aunt and by hiding the fact that her second sister also had a different father.

At the end of the session my countertransference was to feel heavy, confused and nauseous, which I understood to come from Julie's confusion in good and bad object positions for self and other.

Session 9

Julie continues to think more about what 'mess' means to her and I wait for an opportunity to make use of my countertransference from the previous session. Initially she relates mess to not liking the house to be messy but when I invite her to think about what it signifies, Julie connects it to relationships. The fifth sub-theme in Theme 3 Object Relations is identified:

Sub-theme 1.5 Relationships are scary

J: I know I've been a b b b bit bit erm hypocritical sometimes when I say, I would like to have a relationship because I'd like to be looked after but then the more I think about it tw tw the scarier it is tw tw tw tw the scarier it becomes because again it is it is (stop it! [Talking to herself as she shakes her shoulder in an outward movement] sighs) it is somebody in my space. (09/02/16P5L220-223)

The idea of sharing her space is one of the things that make a relationship scary for Julie. There is a connection here with sexual intimacy, which involves the sharing of internal and external space, the object relations in her mind and the relationship in the present. Thinking about it evokes anxiety, which can be noticed in the return of the stammer and the shuddering shoulder movement. This fear is tested when Julie unexpectedly sees her brother Jeff (sexual abuser) at a local supermarket. Being the sexual abuser, he broke the boundary between the space occupied by a sibling and the space shared with an intimate partner. She has not seen him for a number of years.

J: Well yeah, well only when I, only once when I realised that it was him. I didn't I oh it was bugging me because I knew the voice but I does that mean that I'm eradicating him from my brain or something I don't know because I recognised the voice but I couldn't and it was bugging me until he walks towards me up the aisle and I turned and went that is that's my brother and my initial thought was I've got to get out of here. (09/02/1P7L295-299)

In a stream of unconscious narrative, Julie lists the many reasons why she cannot tolerate Jeff anywhere near her. A significant point is that Julie unconsciously makes a comparison between her brother's behaviour towards women and Danny's behaviour towards her. Both had numerous affairs, abandoned the woman when she became pregnant, and both men betrayed her.

So far, the clinical data tells me that in Julie's mind she identifies her husband Keith and her brother Jeff as sexually abusive, and in this session we observe the unconscious connection between Jeff with Danny (father of the children). Danny was the only man that she loved and he broke her heart when he left her alone with two children. Julie changed her strategy when she chose Keith for her third relationship. It would seem that she avoided a broken heart by marrying Keith who she did not love and who repeated the sexual abuse by her brother Jeff. As she talks about their relationship, a subordinate theme of the sub-theme Sexual Abuse is highlighted:

Sub-theme 3.1.2 Hung from a beam

J: *No I think it was a make make do one wasn't it. He was having troubles with his wife. He left his wife and three kids and I didn't even know that he was married which was really stupid of me but anyway that's another story…. Yes… Oh just that image of him hanging me from the ceiling from the b b b b beam thing.*

T: He did that. Hung you from a beam.

J: Yeah Keith did that… This was when we split up we'd split up erm and I did erm after I started having my relationship with the woman erm and every now and then because we was having rocky patches anyway. We was having rocky patches anyway because she was abusive, very, in my opinion, the lesbian community is very promiscuous I've seen that for myself so I would never go at the moment in my head. I wouldn't go back down that route but when we didn't see each other I did see Keith. I did see Keith and that was on one of the occasions that I went… and that was on one of the occasions so I allowed him to control me didn't I.

T: And he hung you from a ceiling during a sex act?

J: Yes and then on one occasion I think I told you, he used to work in the pub and club thingy... Keith said that I could stay 'cos he had a room above the club so he said "yes it's alright you can come and stay" so I went ok, so I went up there and erm there was somebody else in his bed (laughs nervously). Oh jeeps. (09/02/16P13L565-588)

This section conveys something of the dysfunction in Julie's relationship with Keith and how his sexual practice was just tolerated. My shock with this new information that was just slipped in meant that I needed to confirm what I had heard. Their sexual relationship included sadomasochistic practices and him observing Julie with another woman. A significant point is when Julie recognises that she allowed Keith to control her sexually. Julie seems to suggest that the relationship with Keith provided the antidote to broken heart. The problem is that she did not love him and he brought further chaos into her life through his cocaine use and his sexual perversions. Julie also tells us something about her behaviours in that when the relationship with

Martine deteriorated she returned to her abusive husband for sex. This behaviour conveys something of a cycle of shifting between good and bad object positions in her object relations.

The transference countertransference relationship was intense. The overwhelming nature of the countertransference made sense of why Julie held on so tightly to her OCD defences. The countertransference formulation corresponded with the clinical data and provided further evidence of a paranoid schizoid way of operating in her object relations. The countertransference required me to experience a desperate need to protect Julie and an awareness that what was being offered was never going to be enough. This provoked the question of whether Julie ever really felt loved or cared for by her distracted mother. At other times, Julie placed me in an abuser position by staying behind after the session and intently watching me collect the next patient. This experience evoked strong countertransference feelings in me related to betrayal and abandonment. I also felt cross with her; she was intruding where she had no place being. After session 9 Julie telephoned me saying "*I know you just had another patient so I waited until after their session ended to call you*". It was not necessary to place me in this position, but it does confirm that Julie could not negotiate or tolerate a triangular space, where I was involved in relationships that did not include her or that these other relationships did not alter how I felt about her. It also confirms her propensity to split off in her object relations.

Session 12

Julie began the session by reporting that she noticed her checking and tidying rituals increased when her son Mark spent more time at home. At this point she is not making any connection to the previous material. The sub-theme related to Theme 2. Obsessive Behaviours emerges:

Sub Theme 2.1 Rituals stop me feeling anxious and sick

J: *Um … because he's there c c c c c constantly I'm (T: Um) I know I'm constantly more checking more because he's there I'm checking more. All my towels and everything else you know because it's not his fault it's not his fault it's obviously not his fault it's my fault isn't it.*

T: *So you feel as if you are being intruded upon because he is there in your space.*

J: *He's my son I know it's horrible.*

T: *And it's his home.*

J: *And it's his home and it's an awful feeling and I think (voice cracking) he's picking up on it because he's spending quite a lot of time upstairs in his bedroom a hum (clearing throat).*

(10/03/16P1L4-14)

I suggest that the fear of relationships extends to her son and I make a transference interpretation by suggesting that he reminds her of his father.

J: Ah, oh…. I guess it's about I dunno he's a good lad, I guess it's about I guess it's because I know where everythink. What I do I know how I'm doing it and he offers to do the dishes everything but it's pointless him doing it because its constantly on my mind. I'm just gonna go and check it all again and the fact that he's there and I used to worry when he wasn't there I used to ring and ring and ring so I know he's there but it's just God he's my son and I love him you know I love him to pieces but it's just like an invasion.

(10/03/16P1L16-21)

I comment that Mark (son) is the safest relationship that she has and yet she still has an extreme response to him being around her.

J: Yeah (voice cracking) it's a horrible feeling… I'm constantly watching not watching what he is doing. Am I? Yes I am. He's spoken to me about it before constantly ringing him and how embarrassing it is for him. So I know I'm c, c, c, constantly watching and I know he's picking up traits.

(10/03/16P1L28-31)

It is evident that Mark can occupy the good and bad object position; the son that she loves and the son that she is terrified of being close to. In the transference Mark is experienced as if he were his father; the only man she really loved and the man who betrayed her. The return of the stammer indicates that this information is causing Julie distress. I invite her to think about what it means to her to have her son in close proximity. This provides evidence that she is able to love her son but also experience him as an invasion, which evokes OCD. At this point, the sixth sub-theme connected to the Theme 1. Object Relations begins to develop:

Sub Theme 1.6 Invasion, Chaos and Upheaval.

J: *Chaos*

T: *And when I think about chaos I think about things not being as they should be, no control (P: a hum) what do you think about when you think about chaos?*

J: *Upheaval*

T: *Upheaval. Anything else?*

J: *Um, (voice breaking) Oh (deep intake of breath) I've said this before, things going wrong. Um…* Oh, jeeps don't touch anything everything has to be in its place in my head you know. *(10/03/16P2L42-45)*

I make a further transference interpretation suggesting that in the moments she is fearful of Mark; it is as if he were one of her ex-partners. Julie immediately makes the connection to her troubled relationship history; she describes how her marriage to Keith ended:

J: *That (the marriage) was bleeding chaotic he walked down the bleeding aisle high on cocaine. He was addicted to cocaine… so the trust was already gone even before the marriage began*.

Julie explains that the marriage started to deteriorate because of differences in libido. He then took Julie to a gay club.

J: We were still married, we separated in the (laugh) after the millennium, …. Half way through that year, I can see it, things were just getting worse and worse, then he introduced us to this gay club (deep sigh) 'cos we, something he, he wanted to experience. I don't know. I still don't know, whether he's done what he's done with men or what. So yeah, (voice breaking) I heard that he had.

T: He wanted to experience a bi-sexual or homosexual relationship.

J: I guess so.

The chuckle triggered by the thought of separating from Keith, seems to suggest an acknowledgement of blurred boundaries between being together and separate in her relationships, which could be understood to be a blurring between good object who protects and bad object who she has sex with. Julie then describes how Keith introduced her to Martine, the manager of the gay club.

J: Yeah, nothing happened straight away but there was a connection. Um, and ah, that's all there, there, there, that's all there was to it, but Keith kept pushing it and pushing it and pushing it, you know.

T: In what way pushing it.

J: I don't know, sort of like, in a creepy way to do things with her.

Julie connects this to an earlier situation where she found herself set up for three in a bed sex with her husband Keith in a room above the nightclub, as discussed three weeks earlier in Session 9:

J: No, that was before, then he introduced me to the gay club, the thing with other people was before (voice breaking). My attraction to Martine b, b, become, I didn't realise I had that type of feeling in me I really didn't. … She was very very butch but she also made me feel safe… Isn't it strange that all these people that made me feel safe go and ah (voice breaking) do the dirty. Do all the shitty stuff that's happened to me.

This is another realisation moment and evidence of a meaning occurrence; breaking through the unconscious comes the recognition that all the people who she "*felt safe with*", did "*the dirty*", and they are responsible for all of the bad things that have happened to her. Whilst this may in part be true, she is not able to recognise the role that she plays in repeated dysfunctional relationships. In her desire to feel safe, she has chosen those who have the potential to harm. The evidence is that Julie's experience of object relations is mirrored in her intimate relationships; that the one who should provide a sense of safety, actually causes harm. This evokes high levels of anxiety, which is controlled with OCD. Julie goes on to describe the relationship with Martine and there is a return to the sub-theme related to Theme 3. Sexual Behaviours:

Sub-theme 3.2.1 Sex was a chore

J: Yeah 'cos obviously we got together and she was seeing somebody but they split up oh here we go again then our relationship developed and developed and developed over a very short time actually um and um I just just didn't want Keith touching me anymore. I just didn't want any kind of anything you know it

was a chore anyway I said to you it was a big chore. Oh what a mess so yeah we sort of like I ah developed this relationship with Martine and um.

T: A mess, what was the mess.

J: Um… just everything finishing with him getting with Martine.

(10/03/16P4L130-136)

At this point I make an interpretation connecting the messy relationships to Julie's strong obsessional tidying. Julie recognises the connection between her experiences of relationships, the sexual behaviours involved and her obsessive tidying rituals. I then wonder aloud about what caused Julie's sex life to get into such a mess; referring here to the affair, which resulted in two children, the sadomasochistic sex and the gay sex which involved emotional abuse. Initially Julie suggests that:

J: It *goes straight back to what happened with my brother* (Jeff) *doesn't it.*

(10/03/16P5L145)

Julie then connects her experiences of relationships. The Sub-theme Used and abused all my life re-emerges:

Sub-theme 1.3.1 Used and abused all my life

J: I think so because then I started taking control of myself didn't I with regards to my anorexia and you know being around my mum not wanting her to go out. I

think I think I think so I'm not sure… Well I keep saying that its it's all my fault isn't it. I keep saying it's my fault and I allow these things to happen (voice breaking) and I'm trying to fathom out in my head why. : *(10/03/16PL148-155)*

Julie makes a connection between the rape, the beginning of her obsessive controlling behaviours through controlling her food intake and not wanting her mother to go out. For the first time she is alluding to anxiety related to her mother, which is evidenced in "*being around my mum not wanting her to go out*". Julie is also beginning to think about the part that she plays in relationships; although she is typically operating in extremes and suggests that it is all her fault. As the session continues I wonder why Julie allowed Keith to engage in sexual perversions when she was so fearful of it. Julie reports that she felt safe with him, he was very popular and had status locally. The next subordinate theme related to Theme 1. Object Relations is revealed:

Sub-theme 1.3.2 I went back to Keith because I wanted to feel safe

J: *That I would be looked after, but I wasn't looked after was I. (T: No) But I allowed to go I allowed myself to go along with it. I don't know if it was… back then I used to drink a lot of spirits…. If I was paralytic I wouldn't remember what was being done. (10/03/16P8L148-152)*

As the therapy sought to gain further insight into the unconscious motive of her sexual behaviours, Julie described a pattern of fluctuating between Keith and

Martine in order to attain the sense of prestige and safety with Keith even though sex with him scared her, and a sense of safety with Martine. Julie immediately follows this sub-theme by reporting that she fears that her OCD behaviours will affect Mark (son) and she returns to Sub-theme 2.3 connected to Theme 2. Obsessive Behaviours:

Sub-theme 2.3 Rituals protect me from relationships and feelings

J: *I don't know it's all confusing why I allowed myself to get back in that situation with him again with him (Keith) when I hated it. I don't know. I need some answers myself much worse yeah Oh dear (big sigh) and I don't want it to affect Mark. Mother's day I completely ruined it because I couldn't stop checking towels labels around the right way. Mark had been using a towel and not folding the way I like it to be folded. He got really angry with me and said I had ruined everything and he went out. (10/03/16P9L182-188)*

In this session the three main themes of the study are present. Julie describes the anxiety she feels around her son and how OCD helps her to manage proximity and distance in the relationship with him. She is anxious when he is in the family home as it feels like an intrusion, and is anxious when he is out because she does not know what he is doing or when he will return and this feels like abandonment. This is evidence of Mark occupying the good and bad object position, which is also how Julie perceives Mark's father. Furthermore, this seems to trigger the unconscious memory of Julie's experience of being left alone with her delinquent brothers and the resulting

anxiety of not knowing when mother would return. Her experience was that whilst her brothers looked after her in mother's absence, they also abused her emotionally, physically and sexually; giving her an experience of them occupying both the good and bad object positions. This relational experience seems to have formed the pattern for her future relationships. The connection between object relations, sexual intimacy and obsessional neurosis, therefore relates to the exchange between good and bad object positions and her obsessional defence against them.

Session 16

Julie begins Session 16 by disclosing how distressed she is at the thought of me leaving her at the end of treatment. She reports that she fears that she has damaged me by giving me a terminal illness, which means that I will have to leave before the agreed end date of therapy. I am completely baffled about the origin of this assumption and I make a transference interpretation by suggesting that there is something about our relationship, which is activating new memories or feelings that relate to her mother. As a result of this causal interpretation, Julie is able to bring into conscious awareness something that she has defended against since the start of the psychotherapy. Sub-theme 2.4.2 connected to Theme 2. Obsessive Behaviours continues:

Sub-theme 2.4.2 I Want to Understand Why I Do It.

J: *I'm just trying to understand myself... why I've g- why I've c-c-c t-t- tu- developed all these stupid things and I- I'm trying in my mind to ge-get... (exhale) I know it happens for a reason. It-it- these things happen for a reason. They don't just happen, do they?*

I make a connection between Julie's need to control her environment through OCD and controlling her internal world and suggest the OCD rituals involve a form of reparation, that by ensuring order in the cupboard, it protects the self and other against her hostility and rage. There is a significant increase in the stammer. A new sub-theme related to Theme 1. Object Relationships emerges:

Sub-theme 1.7 I do not want to blame mother

J: Not just with mum. I don- you know when you said that it's got something it's more to do with m- my mum and obviously p.p.p.p.p- t.t.t. the fact that she- (cough) Oh God, I can't jus... I can't get my head around how I've co- b.b.b.b- c.c- b.b.b- how I've turned out this way... because of my mum… like I said before I don't w- want my mum to be blamed for... (T: No) How I- how I've t.t.t.t. turned out but then a part of me thinks... oh I don't know... (T: What don't you know?) I don't know, me dad wasn't there, was 'e.

I recognise Julie's anxiety and confirm that Julie's father was not present and her mother was distracted.

J: But that doesn't gi- for m- my-my brother to do what he did to me, so- an' that's not my mum's fault, is it? (14/04/16P1L42-53)

At this point, I attempt to bring into conscious awareness the possibility that Julie fears the aggression that may be unleashed towards her mother's idealised memory if she acknowledges that her mother was somehow responsible for the abuse that happened in her absence, or for not being more available to Julie. I then make a transference interpretation connecting the opening remark about me being killed off by cancer. I suggest that Julie fears that she is somehow killing me off in the same way that she fears killing off her mother's memory. This is another example of a meaning occurrence (Hinshelwood 2013, p. 119). As the dialogue continues, there is a further meaning occurrence confirming the accuracy of the transference interpretation with a return to Sub-theme 1.1 Secrets and Lies connected to Theme 1. Object Relations. This provides an opportunity to learn more about the dysfunctional family that was alluded to in session 8:

Sub-Theme 1.1 Secrets and Lies

J: She (step-sister Tracy) was at home with mum for- for a while. And then she-she went... to make her life in London. (T: Ok) Yeah. So I jus-s-s- you know? Was

hard on my mum. (3 seconds) Always goes back to secrets and lies as well, doesn't it.

T: In what way?

J: In what way, cause obviously we no-no-no-no-no-no-no none (cough) none of us ever knew about Sharon (was told she was her aunt but was actually her half-sister). For so- for very, very long time. (5 seconds) Had a feeling- well, didn't have a feeling but it was always said but not- obviously until I grew up- about Tracy (half-sister). I didn't know ab-ab about her bein' not my dad's daughter, um, obviously not until I was old enough to understand (Shaking movement of shoulders and arm).

T: *Right. That's a very distressing thought isn't it? You are it shaking off.*

J: I dunno, god it's just- I've said before… yeah. It's the lies and deceit, isn't it… I don't think it t-t-t-t-t-t p- if I put it in a- if I put it in a p-p-p (tut) If I p-p-p-p... If I p- (cough) IF I PUT IT... another way... It d- I don't think it really affected m-m- me. (14/04/16P2L92-116)

The distress in the room is palpable as Julie conveys high levels of anxiety, again related to the deceit in the relationship with mother. There is a significant increase in the occurrence of stammer and a movement of rolling back the shoulder and arm. Despite the evidence, Julie suggests that the deceit did not bother her. I challenge the disconnect between what is being said and the affective response and encourage Julie to describe the feeling. The seventh sub-theme related to Theme 1. Object Relations is identified:

Sub-theme 1.7 I do not want to blame mother

J: (Silence 5 sec) I feel in here... bad for Tracy. 'Cause she doesn't even know wh wh who her dad is. (T: Right) She doesn't know who her dad is. ……Yeah, I don't know... I'm not resentful of the fact that mum... left me at home whilst she was up in London- (silence 10 seconds) She did spend a lot- a lot of time with Tracy... Now if I think about that, I know I'm thinking a lot, but if I think about that- maybe that's... her guilt with- with Tracy. Why didn't my mum tell Tracy who her dad was? (7 seconds) Ooh... (14/04/16P3L131-147)

I attempt to discover more about the connection between Julie‘s behaviour and her mother’s behaviour, as both deceived their daughters about the identity of their biological father.

J: It's just come to my forefront as you've said that... And again, I don't wanna blame my mum because she was only advising at the time or giving me advice... Obviously when I became pregnant with Claire... (T: Ah right, yeah) She advised she said to not say anything because I wa- wasn't sure... And obviously because of my anorexia I didn't know that I could have kids anyway.

T: So mum advised you to not say who is the father (of Claire).

J: Yeah. Well I didn't know to be su- to be one hundred per-cent- yeah I had that inkling again I'm not I'm not stupid I had that inkling. (14/04/16P3L158-164)

Julie acknowledges that she knew in her own mind the identity of the biological father, but with the help of her mother she allowed herself to pretend that she did not. Julie then introduces a third sub-theme connected to Theme 2. Obsessional Behaviours:

Sub-theme 2.3 I want to understand why I do it

J: Yeah. I'm just trying to understand myself... why I've g- why I've c-c-c t-t- tu-developed all these stupid things and I- I'm trying in my mind to ge-get... (Exhale) I know it happens for a reason. It-it- these things happen for a reason. They don't just happen, do they.

(14/04/16P3L174-176)

Once again high levels of anxiety can be observed in the increased level of stammering. I return to idea that OCD is a defence against hostility and rage, particularly towards mother, and remind Julie of examples from the narrative. This includes mother spending so much time in London when Julie needed her at home and mother discounting Julie's concerns when Malcolm told her "*today is the day that I am going to kill you*" (19/01/16P12L520-521). This helps Julie access what has been repressed as she connects to the transference relationship with me. This prompts a return to the sub-theme connected to Theme 1. Object Relations:

Sub-theme 1.2 I cannot trust anyone

J: *I just don't trust people it's ju- I just don't trust people. I'm f- this has been the first time that in… I think in my whole life where I've been able to spill everything… to you… ugh this thing is scaring me when it's finished you…. You're gonna take away all my memories… and I don't want to go over it again. (14/04/16P5L289-294))*

It is at this point I make a further transference interpretation by suggesting that it is important to know that I can withstand her rage and that it will not kill me off. This enables Julie to confront a discovery that challenges the perception of her mother and the final sub-theme relating to the Theme 1. Object Relations emerges:

Sub-theme 1.8 What Mother did was wrong

J: *I dug out some photos as well, 'cause obviously we've been talking about my mum. Actually I didn't dig 'em out, the wheel on my bed came off so I had to lift my bed up to put it back and I pulled out one of my drawers... (Sniff) And um... I don't wanna show you them today... (T: But they're in your bag?) In my bag. (4 seconds) Oh... In there, but I don't- don't wanna show them today. (T: Ok) Um... I th- I think it's sought of like, brought to- again I hate the word "dissing" disrespecting. Without disrespecting my mum, it's sort of like- because we've been talking a lot about her... Not a lot about her, but we've been trying to get to so some because you said t- you- (exhale) Right let me s- let me slow down.*

Because I think also you said that, you think your study might be complete because it's got- you think it's probably got something to do with my mum?

T: *I talked about our early relationships. So that would involve mum.*

J: *(silence 8 seconds) Before I developed anorexia my- I di- I forgot- I hadn't forgot, I probably put it back into my subconscious... (Cough) um... um... before I went to... college to train to become a (inaudible)... (Sniff) Um... Between my brother... raping me and me going into- I hate saying that, but it's got to be said. And me g-g-g-g-g-g-g-g-g-g-g going too c-c-c-college... mum c-c-c-c mum, uh... introduced me to somebody... and I don't know if she thought it would help me with my um... confidence... because obviously she never knew about... him. But she introduced me to one of her friends. And I know his name... 'Cause that suddenly came to me and where- I haven't thought about this while I've been having these sessions with you- to do some modeling pictures. That's b- a- th-... I don't know why that hasn't come... to my... the fore of my bra- I guess its cause we're talking about... Now I'm thinking why did sh- why did she do- (cries)…. I had anorexia and I bought a picture of that as well. (Cries) (13 seconds) And if only she was still here, then I'd be able to ask her all these questions, wouldn't I?*

T: *Well it doesn't make sense to you does it…*

J: *(getting up from her chair and sitting back down again) I'm tired what doesn't make sense.*

T: *I get why you would want to get up from your chair and why you are tired, there is something unbearable about it, isn't there. … It does not make sense that a mother would introduce her young daughter to a man who is going to take this kind of photographs of her.*

J: He d- di- some of them are w-w- would you say "tasteful"? But it was... ooh no, they're in here but I can't. .... And I- I I obv- because I've kept the pictures... (Exhale) ooh. At the time I probably thought "Yayy" You know? (Exhale) God….

T: You thought that was normal.

J: Well y- why would I have kept them? Why haven't I shredded them? But because we're talking and trying to piece everything together... My mind is now s- wondering why... my mum would do that. Whenever Claire puts anything online the phone- you know what young girls are like you see all this poutin' and all that- I I w- warn her. And now w-w- and that's just what a normal parent would do, back then when she was doing a lot of you know... pictures and you know? I think I've said to you before - oh why am I doing that? (Referring to getting up from her chair) (14/04/16P5L314-362)

As the session draws to a close Julie asks me to confirm that I "*will be here until the agreed end date of therapy" (14/04/16P5L378-379).* A significant increase in stammer is also evident. My countertransference returns to a familiar sense that Julie fears that I will abandon her with her distress. Returning to my office I feel completely overwhelmed and troubled; I had a strong impulse to lay my head on the desk due to the heavy weight that had been projected into me. I was aware of a strong desire to talk to my clinical supervisor about my distress and I understood why Julie needed to confirm with me that I would be available until the agreed end date of therapy. I made an arrangement to meet with my clinical supervisor; when we met we spoke about the importance of not hiding my feelings from Julie when I see the photographs, as it would be important to normalise my response.

Session 19

Julie brings the photographs to the session and after some initial anxiety slowly takes them out of her bag and hands them to me. My countertransference is to feel tension across my back and I feel nauseous again. The first photograph is of the anorexic Julie and she seeks recognition from me of her childlike body before revealing the remaining photographs. She explains how she recalls the photographer putting her at her ease by taking some possibly more tasteful photographs of her in silky underwear holding a parasol before taking photographs exposing her breasts or genitalia. The nervous tics are present throughout and Julie cries for most of the session with body language that conveyed a sense of shame.

There were very few words in the session but there was a strong communication of intense distress. The photograph of her anorexic self was a powerful communication from Julie that she was still a child when the photographs were taken. It suggested to me that I was able to experience something, which Julie defended against through repression and OCD. I made a countertransference interpretation and simply acknowledged how sickening it must feel to be reminded of such unbearable pain. Julie wept until the end of the session.

Session 20

My countertransference even before I collect Julie from the waiting room is of high anxiety and I wish I could cancel the session, as it all feels too much to

contain. Julie begins by describing her frustrations related to her obsessive taking of registration numbers parked around her car when she comes for psychotherapy and I have a strong countertransference response of it all feeling incongruent but sit silently. Julie then connects two of the themes; Obsessive Behaviours and Object Relations together. A fourth sub-theme related to Theme 2 Obsessive Behaviours is identified:

Sub-theme 2.4 It is not normal

J: Why can't I just park in the space, stop taking these registration numbers. Get out and just do me own stuff. I just can't do it…. Oh God no! (Deep sigh) i u i i i it would mean … it would make me very it would make me very very ah not safe. Look! (Pulling note book out of bag) dates! I SCORE THEM OUT as I go back. It's not normal AHHHH (movement: shaking off shoulder).
(12/05/16P1L4-13)

I attempt to shed light on what is going on in Julie's unconscious mind by using my countertransference, I suggest is that there is something about an attempt to keep herself safe, even though it is a futile task, given the cars are likely to move whilst she is in the session. I suggest that the involuntary tic movements are an attempt to shake off of unbearable feelings that are evoked in the session. The accuracy of the interpretation is confirmed as a meaning occurrence when Julie returns to the Sub-theme 1.8 discussed in Session 16:

Sub-Theme 1.8 What mother did was wrong

J: What did you really think about the photographs last week 'cos I haven't got rid of them yet. I feel like I wonna keep um and I'm constantly guarding where they are… It's just something that's proof that (voice breaking) I've blocked out for so many years (T: Um). …What did you go away thinking about them…. do you think it's got something to do with (sharp exhale silence 8 sec)
(12/05/16P2L55-72)

The intensity of Julie's distress is evident with the sharp intake of breath as she realises that she has concrete evidence of the quality of her object relations. The sharp intake of breath provides a bridge to the next thought, which is OCD and anxiety involving relationships.

I confirm to Julie how painful it was for her to reveal the photographs in the session and for her to acknowledge an unavailable mother who was unable to provide a containing mind. The photographs suggest that mother offered a sexualised way of overcoming anxiety and developing confidence and self-esteem. Instead of seeking to understand the distress behind the anorexia, it seems that Julie's mother provided a defence against it. This clinical data again brings into focus the connection between Julie's object relations, the pattern offered by mother for a sexual relationship, and OCD. Julie continues:

J: I wasn't an adult though was I… (Silence 6 sec) No (silence 9 sec) (exhale) you know I sometimes say to you I just want to be (voice cracking) looked after……. That's probably where it stems from. I wanna be looked after. (12/05/16P4L103-120)

This is a very important communication as Julie recognises that the desire to be looked after comes from an experience of a mother who was not able to offer this experience. Later in the session Julie describes a conversation that she had with Danny's mother about the photographs.

P: And I spoke to her about it (voice shaking) and she said 'what are you gonna do with 'em'. I said 'well I, obviously I need to get rid of them' and she said 'you need to get rid of them now '. She hasn't seen them, (laugh) you're the only person that's seen them, apart from my mum. (Inhale) (3sec) Um … and I actually said to her 'but I don't want to put my mum down'. She said 'I only met', she only met my mum a couple of times. She said "I only m, m, m, met your mum a c, c, c, c, c, couple of times" um she said, but what she did was wrong. 'To me Julie' and this (tearful) really hurt me, she said, "she pimped you out". I said "no you can't say that" (crying 15 sec) she said "well she must have got money for 'em". Why would you say that? I said, I said, "oh Joyce don't say that" (deep exhale) To me it was my mum getting my confidence…. back, or improving, oww, but we're never gonna get any answers, I said this last week didn't I……. She said "she seemed like a nice lady. To me that was

WRONG, what she did was wrong". I said "I know" (crying) thinking about it, it, it, it was wrong of course it was wrong. (12/05/16P7-8L234-265)

It is an extremely painful realisation for Julie to have her suspicions confirmed by her children's grandmother. My countertransference was of something uncontrollable unravelling. The possibility that the photographs were sold by her mother is too unbearable to contemplate and the only way that Julie can consider her actions is to shift mother into the good object position and see it as positive. This helped me to understand again the shift between good and bad object positions and why sexual intimacy is so difficult for Julie. Her mother offered a template that involved the objectifying of Julie's body through sexual gratification to the other, rather than an understanding of an emotionally healthy intimate loving connection.

Session 25

This session followed my 2-week break and provided an opportunity to bring to the conscious mind repressed emotions related to mother. Julie describes isolating herself and not attending properly to self-care. Theme 1. Object Relations is identified:

"*I isolated myself. I felt like, the structure of not coming out (te he) coming out, 'cos I haven't seen you for two weeks (big sniff) so I isolated myself, I do need the structure for myself, for coming here. I mean I don't know I would*

feel so out of my comfort zone. I would need to know if someone is turning up. I trust you I really do but not unexpectedly. I didn't care….. (I'm getting hot again, sweating) I don't care. Oh." (23/06/16P1L7-12)

This data tells me that when I was not available Julie stopped taking care of herself and is evidence that in the transference I am the bad object who abandoned her. There is also evidence of a good object as the giggle after the '*not coming out*' comment suggests an erotic transference, which was vaguely evident, but seems to be confused with the maternal good object transference. This speaks to the confusion felt around objects originating from the shift between good and bad object position of mother and sexual partner that occur in her unconscious mind. Interpreting the transference provides an opportunity to access experiences from the past and to link them to the present situation or dynamic. A fear of abandonment features regularly in the clinical material and transference relationship. The knowledge of this provides an opportunity to support Julie to revive past losses as she considers the end of psychotherapy:

"Um … (tearful) I don't know. I don't know. (Big sigh) I don't know what I'm going to be like when we finish, if this is just a taster of two weeks. No (deep sigh) I've been thinking about it particularly over the last two weeks because obviously Thursday we, w,e,w,e,w,e blar di bar we've had a few days when it's not been the same day but it's gonna be tough. I you know because obviously the last weeks obviously and obviously I told Mark you were on holiday and I'm not gonna be seeing you and he said "what are you gonna do then mum"

(laugh). So if that's just a taster of two week jee wizz, I haven't thought about what I do without you… it gives me a reason to get up … we talk about everything, you know. But it's not gonna go away is it. It's not gonna go away and like we said before. I'm not gonna get any answers". (23/06/16P2L47-59)

The above data confirms the importance of the therapeutic relationship to Julie as she recognises that the bad memories will still be there when the treatment ends. My countertransference suggests that I have not been good enough and I am going to abandon her now my study is complete.

5.5 Discussion

This case study provides clinical data from a patient who has adopted particular extreme OCD defences against a failure in object relations, which can be particularly noticed in her close relationships and sexual behaviours. The data highlights just how frightening a connection with an other is for Julie and describes a construct where all relationships are viewed through a lens of suspicion and fear. The analysis of themes elucidates the connection between object relations, sexual behaviours and obsessional neurosis for this patient. The first theme 'Object Relations' had the highest number of sub-themes with eleven individual themes. The second theme 'Obsessional Behaviours' had five sub-themes, and the third theme 'Sexual Behaviours' had seven sub-themes. A connection between Object Relations and Obsessive Behaviours is evident through the increased levels of anxiety as these themes emerge. A hierarchy in terms of levels of distress can be recognised which

may relate to the emergence of later themes being less available to the conscious mind or an avoidance of speaking about known sensitive information.

5.5.1 Theme 1. Object Relations

When Julie initially began psychotherapy, a pressing matter for discussion related to the first Sub-theme 1.1 'Secrets and lies'. This includes issues related to dishonesty, which is evident in most of her significant relationships. Evidence of high distress is found in the increased frequency of Julie's stammer whenever themes of dishonesty or abuse surface. These themes are re-occurring features in all four of her adult intimate relationships and the relationship with her mother.

When Julie realises that she cannot trust anyone (Sub-theme 1.2), she acknowledges that this has always hindered her developing healthy relationships. She goes on to describe a way of relating that is instinctively obsessional and only permissible when they are "black and white", "filed away" or "concrete". Individuals are either seen as good or bad; they are either longed for or experienced as invasive, creating chaos and causing general upheaval in her life (Sub-theme 1.6). This account would support the first part of this thesis, which relates to the failure in early object relations as described by Klein's Object Relations Theory. The paranoid schizoid position and the early childhood states, including the phantasies of instinctual turmoil, sadistic cruelty and intense anxiety (Klein, 1932, 1935, 1940) can be observed within Julie's narrative and anxious presentation. Julie displays a very serious disability in the arena of relationships dominated by splitting, with high levels of anxiety and

hostile feelings. Originating from object relations with mother, adult intimate relationships are viewed through the same lens and are therefore experienced as terrifying and have to be defended against by OCD.

It is with sense of abandonment that Julie reports "*no one wants to talk to me about what happened*" (Sub-theme 1.2.1). Whilst this theme initially emerges in relation to how the family handled the knowledge of the rape, which happened some thirty years earlier, a second meaning was hidden in the narrative. This relates to her object relations. The clinical evidence for this is found when Julie reported to her mother that her brother had told her "*tonight is the night that I am going to kill you*" (19/01/16P12L520-521) and mother minimised Julie's distress. Reactivating the repressed memory enables Julie to connect with the fear and distress felt by mother's lack of attunement. The impression that Julie subsequently conveys is that she feels persecuted by her family. Klein helps us to locate where this experience may have originated. Klein (1952, p.433) describes persecutory anxiety as the first form of anxiety experienced from birth and locates it as arising out of the death instinct. Klein describes how the death instinct gives rise to fear of annihilation, and describes this as the primordial cause of persecutory anxiety. As if this were not enough, the destructive impulses against the object stir up fear of retaliation. This seems to overlap in the clinical material with an unconscious desire to make reparation, so there is something of a double bind, which brings fear of retaliation and need to make reparation together. From a research point of view, this helps us to locate the origin of the distress, and supports the hypothesis that a relational failure occurred early on in Julie's life.

The Sub-theme 1.3.1 'Used and abused all my life' describes the quality of Julie's significant relationships. As Julie gradually locates distressing memories previously hidden from her conscious mind, it is possible to deduce that she had an experience of a mother who was neglectful. Despite this, Julie held her mother in an idealised position. This idealisation served as a way of defending mother against her destructive impulses; including extreme rage and the sense of abandonment which Julie described feeling on many occasions during the course of the study. This confirms Klein's (1935, p.150) view that the cause of the child's preoccupation is not just about dependence to its mother, but relates to the anxiety and guilt that arise out of its early aggression against her. We know this because Julie reports several times that she "*wanted the best for mother*" and that she "*always worried about mother*, *even after she died*". OCD kept the aggression at bay.

As a teenager Julie employed extreme measures to make her distress visible through being hospitalised with anorexia nervosa. As far as Julie can remember, mother still did not show any concern. Psychoanalytic literature reports that anorexia nervosa often goes hand in hand with an obsessional neurosis and is a behaviour employed to cope with anxiety, which is obsessional in nature and objectified in food and weight gain. It speaks of something, which is good, seen as bad when ingested, which has to be avoided at all costs. Williams (1997) describes what happens when anorexic patients have experienced themselves as recipients of parental projections. She describes a pattern of a defensive rejection of input, which is not necessarily confined to food intake, but extending so widely that it might be referred to as a 'no entry' system of defences (Williams, 1994, 1997). It is possible to link the anorexic

self in Julie with the anti-libidinal self that repels and avoids the taking in of a sexual other, along with the 'no entry' defensive system that avoids any close connection.

Lawrence (2002) describes anorexic individuals who have an internal world of intrusive objects that appear to be over-critically demanding of perfection and loathing of any hint of neediness. Based on Klein's (1928, 1932, as cited in Lawrence 2002) description of the Oedipus complex, Lawrence (2002) describes the core feminine anxiety of intrusion, invasion or damage to the inside that happens when something gets inside of them. This confirms Julie's own reported experience (Sub-theme 1.6 Invasion, chaos and upheaval) of the proximity in the relationship with significant others as well as her sexual relationships.

Lawrence suggests that Bion's (1962) concept of mother acting as the container to her infant's anxieties is crucial for the anorexic individual. Bion describes this as:

> *"Just as exaggeration is helpful in clarifying a problem so it can be felt to be important to exaggerate in order to gain the attention necessary to have a problem clarified. Now the "clarification" of a primitive emotion depends on its being contained by a container, which will detoxicate it. In order to enlist the aid of the container the emotion must be exaggerated. The "container" may be a "good breast", internal or external, which is able to detoxicate the emotion".* (1965 p.141)

Bion goes on to describe what happens when the container (mother) is not able to tolerate the emotion:

> *"Or the container may not be able to tolerate the emotion and the contained emotion may not be able to tolerate neglect. The result is hyperbole. That is to say, the emotion that cannot tolerate neglect grows in intensity, is exaggerated to ensure attention and the container reacts by more, and still more, violent evacuation. By using the term "hyperbole" I mean to bind the constant conjunction of increasing force of emotion with increasing force of evacuation. It is immaterial to hyperbole what the emotion is; but on the emotion will depend whether the hyperbolic expression is idealizing or denigrating".* (1965 p.141)

The concept of 'hyperbole' is significant and helps me to understand the function of OCD when we consider it later in this section. Lawrence (2002) suggests that individuals who develop anorexia have experienced excessive anxieties that were not sufficiently processed or contained by mother. As Julie had an absent father, no one else was available to intervene on her behalf. Neither did she have an experience of a father who idealised her, in order to compensate for mother's lack of emotional nourishment. Connecting this construct to Julie's reported experience provides further evidence of a relational failure and begins to add validity to the hypothesis of this study that obsessional neurosis acts as a defence against an early relational failure.

The "hyperbole" described by Bion (1965) is evident in the clinical data and Julie developed an obsessional neurosis to manage the high levels of anxiety, which came as a result of an intense fear of annihilation. Sadly, the pattern of relational failure was repeated in all of Julie's intimate relations, where she continued to sustain varying degrees of abuse. As the object relational failure continued and intensified, the OCD rituals increased, with the result that any form of connection with another became terrifying.

There is evidence in the clinical data that Julie is unconsciously protecting the other from her rage by her obsessive rituals. This would support Klein's theory regarding the impulses of hatred and aggression. Klein (1932) describes them as "*the deepest foundation of feelings of guilt*", and locates them in the Oedipus complex. Klein offers the following formulation:

> "*When an instinctual trend undergoes repression, its libidinal elements are transformed into symptoms and its aggressive components into a sense of guilt".* (1932 p.26)

In reporting "*all the things I do indoors*"*(06/01/2016P2L96),* Julie is describing the unconscious process of symbol formation; whereby the repetitive actions of the OCD rituals provide reparation, which enables the projected bad objects to be re-introjected as good objects; thus protecting them from her rage. This forms part of her unconscious object relations and can also be noticed in the dynamics

involved in her sexual relations that will be developed later in this chapter. This then provides another link to object relations, sexual intimacy and OCD.

The Sub-theme 1.3.2 'I went back to Keith because I wanted to feel safe' represents a split in her object relations. It is this desperate need to feel protected that took her into her most damaging sexual relationships despite the fear, and led to perverse sexual practices, humiliation and shame. The fact that Julie allowed these to happen communicates something significant. Hinshelwood reminds us that:

> "*Psychoanalysis is concerned with meaning embedded in symbolic utterances, meanings may even be hidden there".* (2013 p. 80)

The hidden meaning behind this communication suggests that she finds relationships murderous or that the boundary between love and hate is extremely thin. Julie was not able to go that far, but she could describe them as scary (Relationships are scary, Sub-theme 1.5). Julie also described her relationship with Martine in these terms, despite the initial hope that a lesbian relationship would offer something less intrusive and more caring. However, what she experienced was public humiliation.

The knowledge of these experiences helped me to begin to answer the research question. For in these experiences I noticed that an object of desire quickly turns into a persecuting bad object. The reality in the relationship with Keith and Martine was that they repeated something of the abusive relationship with the idealised mother.

The hostility felt about this has to be defended against with OCD. The OCD rituals provide evidence of perfection and things being in order, and not the chaos evident in her object relations and sexual behaviours. In the countertransference I frequently recognised a shift in being placed in the good and then bad object positions and was acutely aware of the intense pain that accompanied it.

A breakthrough in therapy came when Julie managed to shift from the idealisation of mother to something, which more accurately reflected her experience. This came in Session 16 after continuing with the interpretation of repressed material. Julie would have me believe that quite by chance she stumbled across photographs that her mother sent her to have taken when she was around fourteen years of age. Out of this material emerged Sub-theme 1.8 "*what mum did was wrong*" *(12/05/16P7-8L265)*. This provides evidence that Julie was able to make the shift from the paranoid schizoid position to the beginnings of the depressive position during the course of psychotherapy.

5.5.2 Theme 2. Obsessional Behaviours

The clinical data identifies that Julie's obsessional behaviours serve to control and order her environment. Objects being the 'right way around' and perfected in a certain order dominates her mind. She describes a complicated ritual of washing up and the putting away of dishes that is almost impossible for anyone else to replicate without making a small error. This ritual serves two purposes; the first is a defensive position in order to keep others at a distance by setting the required standard too high. The second is unconscious and matches Klein's observation of her child patient Erna

described in the literature review. For Julie, the dirty dishes represent her destructiveness towards her objects, which have been evacuated through the unconscious process of projection. The washing up and putting away of clean dishes seems to involve a process of symbol formation whereby the objects are slowly transformed and re-introjected clean, free of any unconscious hostility. A brief period of respite follows until hostile feelings are churned up again, and the process has to start all over again. It is likely that the churning up is evoked when Julie is required to connect with an other again. Furthermore, it has been noticed that the OCD rituals replicate the unconscious process involved in order for coitis to occur, which will be discussed later in this chapter. So again, I have uncovered a link between object relations, sexual intimacy and OCD.

The first sub-theme, Sub-theme 2.1 'I need to be in control', is understood to be a defence against being out of control, as well as providing a sense of protection. The clinical evidence demonstrates that this is most frequently spoken about within the context of relationships, particularly involving sexual behaviours. Examples include: being raped by her older brother; being humiliated in front of others by her second brother when he described her as a "*rug muncher*" in regard to her lesbian relationship with Martine; being humiliated and shamed by Martine when she stripped naked in front of a male friend as a way of conveying to Julie that she was having sex with men; and the sadomasochistic sexual behaviours introduced to her by her husband Keith. The ultimate fear appeared to relate to her own libido and a fear of losing control to the other:

> *"I don't know but I never instigated and I can never remember instigating anything like that so yeah that would be really frightening for me as well as the being out of control in their house"*
> *(26/01/16 P5L139-140)*

Her aversion to untidiness seems to be a defence against how she perceives herself and understood to be a way of repairing internal chaos through an external action:

> *"I reckon I've always been a messed up kid poor kid. Messed up kid into a messed up adult". (26/01/16 P12L420-425)*

This hypothesis is confirmed when Julie reports "*rituals stop me feeling anxious and sick" (*Sub-theme 2.2). The significance of the rituals in the here and now is evidenced as well as providing a defence against internal chaos and destructive or hostile thoughts. It is clear that obsessional neurosis is the mechanism through which Julie manages all of her daily interactions. Julie recognises the awfulness of her situation when she realises that "rituals protect me from relationships and feeling" (Sub-theme 2.3). This acknowledgement has a positive impact upon Julie, despite the pain and sadness that it evokes. The next sub-theme to emerge is "I want to understand why I do it" (Sub-theme 2.4). Julie gradually comes to realise that obsessional neurosis provides a barrier between her and the other, and thus helps her to keep a distance, as well as suppressing her hostility and rage.

5.5.3 Theme 3 Sexual Behaviours

Julie's narrative in relation to sexual behaviours is found in four sub-themes. The first sub-theme is 3.1 Sexual Abuse, which contained two subordinate sub-themes: 3.1.1 "My brother raped me" and 3.1.2 "He hung me from a beam". The impact of sexual abuse by Julie's brother is present from the very beginning of treatment. Whilst the sexual act itself must have been traumatic for Julie, the overriding distress seems to be located in the connection between this single act and the repeated failures in her relationships, which connected to Sub-theme 1.3.1 "Used and abused all my life". This included emotional and physical abuse and general neglect. In Session 8 Julie's free association to the fear of sex is:

> *"Someone being close… penetration… being hurt physically and emotionally". (26/01/16 P5L146-150)*

Whilst this is clearly describing her experience of coitus, it also describes Julie's experience of object relations, where both are experienced as intrusive and harmful. This supports the findings of Lefer reported in the literature review:

> "*A psychosomatic experience that is a trajectory through time from earliest experiences of intimacy and security to adult maturity and bodily functions. Sexuality is not just physiology: cognitively, a personal meaning is involved*". (1997 p.18)

Julie's narrative reflects what Klein (1930) describes as the context of the infant's first experience of the parents' coitus and the phantasies that accompany it, and helps to locate the origin of Julie's distress. Klein demonstrated that the experience evokes anxiety, which is internalised, as a result of the oral-sadistic introjection of the objects and becomes part of the gradually developing superego. Bion's (1959, 1962a, 1962b) theory regarding the consequences of maternal failure at this stage is the development of a destructive, envious superego, which prevents the individual from acquiring healthy relationships with any object. Of particular interest is the recognition (Britton 1998) that a good object can only be regained by splitting off mother's perceived hostility and linking and assigning it to a hostile force, as this would speak to the hypothesis of this study in relation to the unconscious splitting processes required for the obsessive individual to engage in a sexual relationship.

The lesbian relationship with Martine provides an appropriate context within which to explore this phenomenon. The relationship developed after her husband introduced Julie to Martine at a time when the dysfunctional marriage was ending. Julie initially felt safe, with a strong butch woman, and there were aspects of their closeness that she enjoyed. It also provided an exit strategy from an abusive husband, leaving a bad object for an idealised good object. However, this too quickly became psychologically abusive and resulted in Julie feeling shamed and humiliated. The relationship was interesting in that it seemed to represent something of a detour. I formed this impression after reflecting upon my countertransference response of feeling lost when Julie's narrative took a detour. Freud wrote about withdrawals into what he called "retiring in favour of someone else". In his paper "The Psychogenesis

of a Case of Homosexuality in a Woman" Freud (1920) describes a case study of a young girl who began a lesbian relationship and somewhat shamed the family. In describing the mother's response, Freud reports that mother had enjoyed her daughter's confidence about her passion. Freud went on to suggest that:

> *"She retired from the attention of men in favour of her mother, to remove one cause of her mother's hostility to her".* (1920 p.284)

This is a significant as object relations with mother appears to be pivotal in some cases of obsessional neurosis. It has been noticed in other cases that a sexual relationship evokes a sense of guilt towards mother. It appears that this lesbian relationship provided the possibility for identification with mother and negated the need to unconsciously kill off mother. Julie initially became involved with Martine at the request of her husband, even though she found some of the sexual behaviours *"creepy". (10/03/16P2L103)*.

The inability for sexual partners to be experienced as good alongside a good mother object is an enactment of an unresolved Oedipus complex. In order to achieve coitus, the other has to be psychologically killed off. The knowledge of hostility then requires reparation through OCD. It also suggests an inability to operate within a triangular space as discussed by Britton (1998). This is where it becomes possible to be a participant as well as an observer in a relationship. Britton sees this as coming from:

> "*The consequences of the failure of maternal containment is the development of a destructive, envious superego which prevents them from learning or pursuing profitable relations with any object. (1998: p. 47)*

Julie's sexual practices reflect a projection from mother who sexualised her in a particular way as evidenced in the pornographic photographs. All of Julie's sexual relations after the relationship with Danny were abusive. Danny, the father of her two children, was the only person Julie ever really loved and enjoyed a sexual relationship with, even though he could not be faithful to her, thereby repeating something of the object relations with mother. It is worthy of note that all of the sexual relationships after Danny were abusive, dysfunctional relationships, allowing mother to be returned to the idealised position.

Embedded in the thesis of this study is the hypothesis that in OCD, the good object is preserved by splitting and investing the bad object in the sexual partner who, in sexual relations, restores the good object by becoming the good object for internalisation. In this way, the good mother is restored. The sexual partner returns to the bad object position, and so the cycle repeats itself. This hypothesis was first formed through direct experience of treating other OCD cases, and evidence from Julie's object relations supports this hypothesis. In the experience of treating Julie, the very severe OCD symptoms hindered exploration of this hypothesis in as much detail as is possible in less severe cases. Nonetheless, it has been possible to make the connection through the interpretation of unconscious material. In some less severe

presentations, OCD rituals are directly related to the safety of mother. In the case of Julie, her experience of significant relationships was so dominated by abuse or neglect that the thought of connection with an other evoked high levels of anxiety, and so it was not possible for her mind to go to the conscious protection of the other.

5.6 Summary

At the end of the qualitative study I have been able to answer research question 1 and subsidiary-questions iii) and iv) and confirm the study hypothesis to be true.

In the language of the Sexuality Scale Questionnaire used in the quantitative study, Julie's sexual perceptions highlight extremely low sexual esteem and a negative sexual preoccupation. The case study provided further evidence to better understand what this looked like in reality. Julie's object relations were often terrifying and unsupportive; she sought to manage high anxiety levels evoked through her object relations with OCD, which also provided a barrier to connection with an other.

The use of transference and countertransference played a significant role in this research. The transference formulation suggests a paranoid schizoid way of relating. Extreme anxiety related to loss of the object, which includes a repressed potential to kill off the other through neediness or aggression is one part of the split and was evident in the interactions with me. The other position

was a desperate need to hold on to me and is connected to the desire to hold onto an image of mother as a good object. Hostile feelings, and at times murderous rage, were also identified in the transference. The counter transference formulation evidenced of a paranoid schizoid way of operating, with love and hate as well as intense emotional pain being experienced by me throughout the treatment.

Chapter 6 Discussion and Conclusion

6.1 Introduction

This chapter includes a reflection on the method used, evaluation of the research and results, along with discussion of the limitations of the study and suggestions for future research. Dissemination of results will also be discussed.

6.2 Methodology

This study sought to discover if there is a connection between object relations, problems with sexual intimacy and Obsessive Compulsive Disorder. A systematic literature review considered quantitative and qualitative research along with Meta synthesis studies and expert papers, as a way of understanding how OCD is being understood within a mental health environment.

I used a mixed method for this study; the quantitative study involved 2 validated measures, the Obsessive Compulsive Inventory (Foa et al. 1998) and Sexuality Scale (Snell & Papini, 1989) and an unvalidated demographic questionnaire. In the single case study, I used thematic analysis using the model put forward by Braun & Clarke (2006) along with Klein's Object Relations theory and the paranoid schizoid position as the psychoanalytic construct within which to analyse the clinical data.

6.2.1 Reflections on the Method

At the outset of this study I was aware that using a mixed method for what is psychoanalytic research is highly unusual and I opened myself up to criticism from the psychoanalytic community and others. Despite this I felt a determination to continue with the method and there were many obstacles and challenges along the way. The motivation came from a strong desire to demonstrate that mixed methods are not solely the domain of psychologists but that psychoanalytic psychotherapists can adapt their research practice and meet the current demands of the research community. There were times during the analysis of data that I wished I had not chosen this method as it stretched me to the very limits of my capabilities and there were times when I wanted to give up. Now that I have come to the end I am pleased that I completed the process.

6.3 Evaluation

This study will be evaluated using Greene et al. (1989) five-point model as discussed by Bryman (2006). Greene reports the essential components of a mixed method study to be triangulation, complementarity, development, initiation and *expansion.* (See Section 3.3, p 69)

In terms of triangulation I was able to evidence corroboration between quantitative and qualitative data. Both found evidence of OCD and negative sexual esteem and negative sexual preoccupation.

The complementarity of the mixed method was evidenced in the enhancement of the quantitative data and quality of data from the single case study. The psychoanalytic concepts of transference, countertransference, projection and projective identification uncovered unconscious material relevant to the study. The thematic analysis was able to string together the relevance of clinical data, thus enhancing the findings. Psychoanalytic research as a science has a long history of being challenged (Mason 1984; Crews 1993; 1998; Fish 1989 and Webster 1995). This study has demonstrated, using Hinshelwood (2013) model of research on the couch, that it is possible.

The single case study provided complementary clinical evidence of a pattern of operating out of the paranoid schizoid position (Klein, 1932) in all of the patient's significant relationships. The idea of sexual relations was experienced as terrifying and something to be avoided. This supports the findings of Aksoy et al. (2012) whose study found that sexual avoidance was found in 60% of OCD patients and is attributed to the absence of a partner (Monteiro & Noshirvani, 1987; Freund & Steketee, 1989).

In terms of development, the use of validated questionnaires provided important detailed data to support the qualitative study in answering the research question. The analysis of the quantitative data did not evidence a correlation between obsessive compulsive disorder and sexual difficulties; however this may be possible using a larger sample in future studies.

Initiation proved to be more challenging. The study found contradiction between the two methods. The quantitative study did not find a statistical correlation between sexual perceptions and OCD, whereas the qualitative study did find a connection between object relations, sexual difficulties and OCD.

The mixed method was successful in 'extending the breadth and range of enquiry by using different methods for different inquiry components' (Greene et al., 1989, p. 259, Bryman 2006, p.105) as evidenced above. At the end of this study I have been able to:

1. Answer the questions set out in the Introduction and have made a contribution to theory and clinical practice in the understanding and treatment of Obsessive Compulsive Disorder.
2. Make a contribution towards theoretical understanding of the unconscious process involved in sexual relations for the patient in the study, who suffered from severe OCD.
3. Open up discussion regarding the value of treating OCD patients in the NHS Secondary Care Metal Health setting using psychoanalytic psychotherapy.
4. Offer an effective treatment model for OCD patients in the NHS.

6.4 Implication for Treatment in the NHS

This study carried out in the NHS has demonstrated that psychoanalytic psychotherapy is successful in treating OCD. This position is supported by evidence of other case studies presented (Bisogni, 2017; Tyson, 2009; McGehee, 2004).

The popular assumption in the NHS is that CBT is sufficient obscures the complexity of OCD and results in either a revolving door situation where patient re-present for treatment, or they are referred to costly out of area specialist services. The 2013-revised NICE Guidance for OCD recommends the assessment of functional impairment to be considered and describes the treatment required for mild, moderate and severe difficulties. The guidelines recognise that OCD may be part of a comorbid presentation including severe depression and personality disorder, among other anxiety presentations. For patients with severe OCD, as in this study, NICE recommend a referral to Secondary Care services for a combined treatment of SRI's and CBT (including exposure and response prevention), whilst they are waiting for treatment. This point seems to be lost somehow and begs the question about why this information has become diluted to the point that it is now a popular understanding that CBT is the recommended treatment option for OCD. Why this is not more fully understood by clinicians, managers and commissions of Psychological Therapy Services is also perplexing. This raises the question around publicity and exposure of clinical evidence, something which clinical psychologists seem much better at than their psychoanalytic peers.

This case study evidences that CBT treatment of OCD rituals with behaviour activation was not sufficient to sustain reliable change. For Julie, change became possible only after exploring her fear of relationships and sexual history, and making the connection between her unconscious mind, her agoraphobic anxiety and the function of OCD. This is supported by the findings of Lefer (1997) who highlight the significance of taking a detailed sexual history at assessment with OCD patients, and Wetterneck & Hart (2012) who highlight the importance of other non-CBT models and the central role intimacy and other interpersonal aspects play in the treatment of OCD. Interestingly, when reviewing evidence, the revised guidance (NICE, 2013) confirms that treatment hours are a factor in success rates. This acknowledgement provides a window for evidenced based studies of psychoanalytic treatments in the NHS.

NICE (2005) recommend that three things are considered at assessment: patient choice, clinical judgment and evidence base. They also recommend that patients should be informed of treatments being chosen that have insufficient evidence. Further consideration is required in relation to clinical excellence. This is particularly significant as OCD patients often present with comorbidity that requires flexibility and an understanding of the unconscious in order to elucidate the hidden meaning behind the ruminations. Benns-Coppin (2008) cites Chambless (2002) who argues that an incorporation of a variety of skills should be more readily recognised and incorporated into NICE Guidelines. There is recognition in the full guidance (2005) that people with high levels of comorbidity require greater levels of expert care from those who are experienced in treating OCD, and this recommendation is not

confined to one treatment model.

This provides an opportunity for organisations, such as The Professional Associations Research Network (PARN), to offer an expert voice to Government and NICE about other effective treatment models. Furthermore, it is incumbent on professional registration bodies such as UKCP and BPC as well as universities to raise the profile of evidence based research other than RCT's and to promote excellence and high standards in psychoanalytic thinking. In recent years, since the implementation of IAPT services, UKCP and PARN have been proactive in their representation to Government and NICE and have been actively providing evidence of psychotherapies in their desire to make psychoanalytic psychotherapy accessible to all.

Perhaps ultimately the driving force is an economic one. Therefore, a dialogue is needed with commissioners of Psychological Therapy Services within the NHS to encourage considerations related to quality versus economy; it is incumbent upon treatment providers to compile evidence to highlight re-presenting OCD patients and total treatment lengths in order to gain a better understanding of true treatment costs, bringing into the equation the revolving door of CBT treatments and perhaps onward referral to Specialist Services compared with a treatment of Psychoanalytic Psychotherapy.

There is some hope on the horizon in the form of the DSM V guidance now that OCD has been revised and is now classified as a separate section with other anxiety driven conditions. In the past, classifying OCD with general anxiety disorders has led to problems in identifying the many different presentations of the disorder (Bisagni, 2017). This also made it difficult to find common groups for research for those with a psychodynamic orientation. The revisions in the new DSM V allow for a dialogue with a psychoanalytic approach. Bisagni highlights that:

> "*The new classification is more precise and allows a better comparison with other major psychiatric conditions, especially depression and thinking disorders, and in this respect allows a more cogent interrelation with the psychoanalytic vertex".* (2017, p. 4)

6.5 Limitations

The theoretical framework used in this study is Klein's Object Relations Theory. It is recognised that other perspectives could be offered within which to explore the problem.

A further limitation is that the study has not considered obsessional neurosis within a context of other personality disorders. A study by Tükel, Polat & Ozdemir et al. (2002) reports that up to two-thirds of patients with OCD will have another major psychiatric diagnosis. Up to one-third of patients with OCD may develop a comorbid depressive illness, with depressive symptoms having a negative effect on outcome.

Whilst a study by Rasmussen, S. & Tsuang, M. T. (1986) found that although anxiety is a common factor in both OCD and other anxiety disorders, the lifetime risk of having another anxiety disorder in OCD is elevated. The most common comorbid anxiety disorders reported in a study by Welkowitz, L.A., & Struening, E.L. et al. (2000) were found to be: generalised anxiety disorder (17.9%); social phobia (2.1%); and panic disorder (1.8%); thus, adding to the anxious difficulties for the obsessional individual.

6.6 Implications for Clinical Practice

The implications for clinical practice relate to two specific areas:

6.6.1 NHS Secondary Care Psychological Therapy

It has already been established that within the NHS Secondary Care, Mental Health treatments are governed by the NICE guidelines. Despite this, there is an increasing body of evidence on the value of treating OCD with psychodynamically informed interventions (Gabbard. G., 2001; Leib. P., 2001; Esman. A., 1989, 2001; Benns-Coppin, 2008; Bisagni, 2017). There remains pressure on time-limited interventions to provide a quick easing of symptoms, despite the knowledge that this provides little long-term gain, with the likelihood that the patient will need additional support in the future. Evidence from this case study highlights the complexity of feelings, thoughts and intrusive memories that require more than a behavioural approach; a treatment that addresses the unconscious will provide a long term easing of symptoms.

Benns-Coppin (2008) writing about the value of integrated therapeutic approaches highlights the difficulty for psychoanalytic psychotherapists working in Secondary Care Psychological Therapies when she reports in the conclusion of her study:

> *"Coupling the skills of different therapies can be effective in treating complex patients that are referred to Secondary Mental Health Services. Conversely, restricting practice to single orientation therapies can lead to an impoverished care for patients and a diminution of invaluable therapeutic skills which may become underused, undervalued and lost in the practice of mental healthcare within the NHS".* (2008, p.262)

The case study evidences that psychoanalytic treatment uncovered unconscious material that influenced the OCD behaviours, which then provided an opportunity to explore and discuss innermost fears. The recommendation post psychotherapy for Julie was for Exposure and Response Prevention (ERP) Therapy. This confirms the findings of Leib (2001) who found that no single modality of treatment is likely to be appropriate or maximally effective in the treatment of severe OCD. Her paper details the ways in which various modalities were integrated into the patient's analysis, both practically and analytically. It shows how the different treatment approaches can be complementary and lead to an enhanced therapeutic benefit.

6.6.2 Kleinian and Post-Kleinian Psychoanalysis

The findings of this case study have implications for therapy of Kleinian and post-Kleinian psychoanalysis regarding internalising the (m) other as whole and good (Klein, 1935), or internalising the thinking capacity of the (m) other (Bion, 1962; Britton, 1992). This is particularly relevant when thinking about the experience of self and other in relation to sexual expression, as attacks on alpha-functions brought about by hate or envy destroy the possibility of a conscious contact with self or another as live whole thinking objects. It follows that that it also leaves the personality unable to have an authentic relationship with the libidinal self as only beta-elements are available for whatever activity happens instead of thinking and beta-elements are employed in evacuation of negative thoughts through projective identification. This would have a severe impact on the possibility of a healthy sex life. The transformation of experience available through the process of Bion's theory of 'containment' would need to be thought about, and where this is lacking, the process of psychoanalysis will detoxify the extremely painful memories that debilitate the individual, hinder sexual expression and contribute towards the OCD becoming so overwhelming. Exploring the connection between high levels of anxiety and sexual perceptions to uncover the hidden meaning will support the development of a more healthy sense of the libidinal self.

6.6.3 Dissemination of Results

The next step will be to disseminate the results of this study within the NHS through presentations at Countywide Psychological Therapy Team meetings as well as offer information sessions to staff and Consultant Psychiatrists in the Community

Mental Health Teams.

I will seek to submit a paper on my findings for publication within professional journals and deposit my thesis with the University of Essex Research Repository with permanently restricted access to sensitive data.

6.7 Further Research

This case study was of a brief therapy within an NHS setting, which did not allow for a more in-depth exploration of the patient's early experiences. A case study of longer duration would provide a valuable learning opportunity to learn more about the phenomena. The link between sadomasochistic sexual behaviours and obsessional neurosis was not considered and this needs to be better understood. This would concur with the findings of Faisander et al. (2012) and Wetterneck & Hart (2012), who found that further research is needed to better understand sexual behaviours, including out of control sexual behaviours of patients with OCD.

A further research opportunity would be to compare the two cases that completed stage two of the current study. As the second case was a back-up case, the clinical material has not been used. This would provide data to compare and contrast the early object relations experiences and levels of sexual dysfunction of a male and female OCD patient.

As highlighted in the quantitative results chapter, the same study could be repeated involving a significantly high number of participants with the aim of proving a correlation between the Sexuality Scale (Snell & Papini, 1989) and Obsessive Compulsive Inventory (Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., & Amir, N., 1998).

6.8 Conclusion

Obsessional neurosis is well documented within psychoanalysis as originating from a 'defensive preference' going back to the earliest times of life. This study set out to develop understanding about the connection between object relations, as discussed by Klein, sexual intimacy and obsessive compulsive disorder. The study identified the unconscious dynamics, which are used to manage intense anxiety and aggression. This related to Klein's paranoid schizoid position and highlighted the central role for the use of projection, symbol formation and sublimation. It was also able to uncover through the use of transference and countertransference material, the unconscious action involved in the interplay between mother and sexual partner.

The originality of this study is found in highlighting the unconscious dynamic involved in the exchange between good and bad object positions with mother and sexual partner in order for the obsessive individual to engage in a sexual relationship. This original idea is of significance and would benefit from further research in order to better understand the frequency of this phenomenon in obsessional neurosis and to better understand the OCD group most likely to suffer from it.

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Appendices

Appendix A NHS Approval Letter

NHS
Health Research Authority
National Research Ethics Service

NRES Committee London - South East
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

28 July 2015

Mrs Beverley Mears
Senior Psychoanalytic Psychotherapist
Kent and Medway Partnership Trust
Canada House
Barnsole Road
Gillingham
ME7 4JL

Dear Mrs Mears

Study title:	**Is there a connection between attachment difficulties, problems with intimacy and obsessive –compulsive symptomatology?If so, what is it?**
REC reference:	**15/LO/1129**
IRAS project ID:	**176785**

Thank you for your submission, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Margaret Hutchinson, nrescommittee.london-southeast@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

A Research Ethics Committee established by the Health Research Authority

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Information Leaflet]	1.3	02 May 2015
Covering letter on headed paper [Covering Letter]		29 May 2015

A Research Ethics Committee established by the Health Research Authority

Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor/Indemnity Insurance]		06 August 2014
GP/consultant information sheets or letters [Professionals Information sheet]	1.2	25 March 2015
Letter from sponsor [Sponsor letter]		01 June 2015
Letters of invitation to participant [Letter of invitation to participate]	1.1	25 March 2015
Non-validated questionnaire [Patient Demographic Questionnaire]	1.0	29 May 2015
Participant consent form [Consent form - Quantitative]	1.1	29 May 2015
Participant consent form [Consent Form Qualitative]	1.1	24 July 2015
Participant information sheet (PIS) [Participant Information Sheet]	1.5	24 July 2015
REC Application Form [REC_Form_04062015]		04 June 2015
Research protocol or project proposal [Research Protocol]	1.3	12 April 2015
Summary CV for Chief Investigator (CI) [Chief Investigator's C.V.]		12 May 2015
Summary CV for supervisor (student research) [Susan kegerreis CV]		12 May 2015
Validated questionnaire [Obsessive Compulsive Inventory]	1.0	29 May 2015
Validated questionnaire [Attachment Style Questionnaire]	1.1	29 May 2015
Validated questionnaire [Sexuality Scale validated questionnaire]	1.2	29 May 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

A Research Ethics Committee established by the Health Research Authority

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/LO/1129	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp M. Southgate

On behalf of Professor David Caplin
Chair

Email: nrescommittee.london-southeast@nhs.net

Enclosures: After ethical review – guidance for researchers

Copy to: *Ms Sarah Manning-Press*

Mr Richard Collins, RM&G Consortium for Kent and Medway

A Research Ethics Committee established by the Health Research Authority

University of Essex

Research and Enterprise Office
T 01206 872922
F 01206 873894
E reo@essex.ac.uk

www.essex.ac.uk/reo

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom
T 01206 873333
F 01206 873598

www.essex.ac.uk

1 June 2015

To whom it may concern

Is there a connection between attachment difficulties, problems with intimacy and obsessive –compulsive symptomatology? If so, what is it?

I am pleased to confirm that the University of Essex will act as Sponsor under the Department of Health Research Governance Framework for Health and Social Care for the following research project undertaken by one of our postgraduate students:

Chief Investigator:	Mrs Beverley Mears
Department:	Centre for Psychoanalytic Studies
Project Title:	Is there a connection between attachment difficulties, problems with intimacy and obsessive –compulsive symptomatology? If so, what is it?
Academic Supervisors:	Mrs Sue Kegerreis
Workplace Supervisor:	Dr James Osborne, Consultant for the Secondary Care Psychological Therapy Service, Kent and Medway NHS and Social Care Partnership Trust

The University will provide indemnity against negligent harm caused as a direct result of our employees' and students' actions.

Yours faithfully

Sarah Manning-Press
Research Governance and Planning Manager

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Appendix C Professionals Information Leaflet

Information Sheet for Professionals

Clinical Study

Introduction
This study is being conducted as part of a Clinical Doctorate with The Centre for Psychoanalytic Studies at The University of Essex. The purpose of the study is to find out if there is a connection between attachment difficulties, problems with intimacy and Obsessive Compulsive Disorder. If a connection is found then a recommendation will be that other treatment options should be available to treat the underlying issues. The study is being undertaken within Secondary Care Psychological Therapy Service and the chief investigator is Beverley Mears, Senior Psychoanalytic Psychotherapist.

Methodology
The study will include quantitative and qualitative measures.

The first stage of the study:

Quantitative Measures
Most people taking part will be asked to complete 4 questionnaires. These questionnaires have been validated to accurately evidence what the questions are seeking to answer. They include:

1. A Demographic Questionnaire covering demographic information relevant to the study.
2. The Obsessive Compulsive Inventory (OCI), which asks about the nature of OCD thoughts and behaviors.
3. The Sexuality Scale (SS), which is an objective self-report questionnaire designed to measure three aspects of human sexuality; *sexual esteem, sexual depression* and *sexual preoccupation*.

The questionnaires will be completed by the patient with the chief investigator during an individual appointment set up specifically to complete the questionnaires. The session will last between 60 -90 minutes.

For most participant that is all that will be required.

The second stage of the study:

Qualitative Measures
A small number of participants (a maximum of 2) will then be invited to take part in the aspect of the research study that will look at themes explored during the patient's individual psychotherapy sessions. These sessions will be recorded, so that themes can be accurately identified. The recordings will then be transcribed and the information will be analysed in order to identify the important themes, which might connect to the study. Any patient identifiers

(e.g., names, jobs etc) will be changed or removed to avoid anyone being recognized from the data. Once the recordings have been transcribed, they will be deleted.

All patient information will be stored in line with KMPT's Record Keeping Policy. The completed questionnaires will be stored in a locked filing cabinet until the research study has been completed. The responses will then be analyzed and recorded on a database ready for the lead researcher to write up as part of a doctoral thesis. The completed questionnaires will then be shredded.

Participants

Inclusion Criteria:

- Patients within Medway Secondary Care Mental Health Service presenting with Obsessive Compulsive Disorder (OCD) (Axis 1 disorder).
- Patients willing to give informed consent to participate in the project

Exclusion Criteria

- Obsessive Compulsive Personality Disorder (OCPD Axis 11 disorder).
- Patients presenting with a psychosis
- Patients in crisis.

Participants will not be excluded on the grounds of race, gender or sexual preference.

Main Ethical Issues

Ethics Approval

Ethics approval will be sought from the Integrated Research application System (IRAS) prior to the commencement of the research.

Consultation

Consultation will be sought with the Patient Experience Group, prior to the commencement of the project regarding the collection of data through the completion of screening tools to ensure that data is collected in a patient friendly manner.

Informed Consent and Confidentiality

A participant information sheet will be developed to provide potential participants with information regarding the rationale for the study and steps taken to ensure participant confidentiality. The anonymity of all participants will be ensured. Prior to dissemination of data, all identifying data will be removed.It will also be made clear that participants are free to withdraw from the research at any time without any negative consequences.

This project will take into account ongoing consent of all participants. This will be emphasized in a participant information leaflet. Participants may give informed consent in principle prior to the start of treatment, however they may change their mind and in these instances participants reserve the right to withdraw their consent at any time. All information will be treated confidentially

in line with Trust policy. This will be outlined within the participant information sheet.

Participants will be invited to contact the researcher and research team with any queries regarding the study.

Feedback of Results
At the end of the study, the chief investigator will hold a presentation for participants and representatives from PALs. A written report will also be available for those participants who do not wish to attend the presentation event.

What happens next?
If you have any patients on your caseload who might be suitable for would like to be art of this research study please speak with them initially about the study. If they express an interest in the study please let Beverley Mears know.

When will the study begin?
I am hoping that I will begin to offer information sessions in August 2015 with a view to starting the research from September 2015

How many participants will you need?
I will need around 50 patients to complete the first stage of the study, which is answering the 4 questionnaires. I will then only need 3 volunteers to go on to stage 2 and the recorded psychotherapy sessions.

What happens after the patient has completed the questionnaires?
Most patients will go on and be seen by clinical psychologist or psychotherapist for their psychological intervention as normal. Only a very small number will continue in the study. Being involved in the study will not hold up their psychological intervention.

How long will the study last?
I am anticipating that the study will last up to 1year in total.

What if I have questions about the study afterwards?
If you have any questions about any aspect of the research study you can speak to the lead researcher at any time. Her contact details are:

Beverley Mears
Senior Psychotherapist

Appendix D Patient Information Leaflet

NHS ADDRESS REMOVED

Introduction

In this leaflet we hope to answer some of your questions and enable you to make an informed choice about whether you would like to be involved in this study and what might be involved.

What is the study about?

This study is being completed as part of a Doctoral programme of study based at The University of Essex and The Centre for Psychoanalytic Studies. The aim of the study is to see if there is a connection between a presentation of obsessive compulsive symptoms and difficulties with sexual intimacy and other forms of close relationships or attachments.

What will be involved if I decide to take part?

The study will include two different aspects; most people taking part will be asked to complete 3 questionnaires. These questionnaires are recognized as being able to accurately reflect what the questions are looking for. They include:

1. A Demographic Questionnaire, which asks about you, your age, your marital status and other similar questions.
2. The Obsessive Compulsive Inventory (OCI), which asks about the nature of your OCD thoughts and behaviors.
3. The Sexuality Scale (SS) measures three aspects of human sexuality; *sexual esteem, sexual depression* and *sexual preoccupation*.

These questionnaires will be completed with you and the lead researcher, who is a Senior Psychotherapist in the Psychology Service in Canada House. An individual appointment will be arranged with you specifically to complete the questionnaires. The session will last between 60 -90 minutes.

For most participants that is all that will be required.

A small number of participants will then be invited to take part in the aspect of the research study that will look at themes explored during the patient's individual psychotherapy sessions. These sessions will be recorded, so that themes can be accurately identified. The recordings will then be transcribed and the information will be looked at in order to identify the important themes, which might help to better understand how OCD impacts on your life. Any information that you could be identified by (e.g., names, jobs etc.) will be changed or removed so that your identity is protected. Once the recordings have been transcribed, they will be deleted.

Can I volunteer to be part of the second stage of the study?

Yes you can talk to Beverley, the lead researcher about this when you meet with her at the information session.

How will my information be kept safe?

All patient information will be stored in line with KMPT's Record Keeping Policy. Once you have completed the questionnaires they will be stored in a locked filing cabinet until the research study has been completed. The responses will then be analyzed and recorded on a database ready for the lead researcher to write up as part of her doctoral thesis. The completed questionnaires will then be shredded.

How will I know if I am a suitable candidate for this study?

You will be suitable candidate if:

- If you struggle with Obsessive Compulsive symptoms including OCD thoughts and/or behaviors I would like you to be involved
- If you are willing to give informed consent to the use of anonymised quotes being used in publications
- If you agree to the psychotherapy sessions being recorded

It will not be a good idea for you to be involved in this study if you are:

- Suffering with psychosis.
- In crisis at this stage.
- You do not want to give consent to the information, which you give being used.

What happens next?

If you would like to be part of this research study the next step will be to attend an information session with the lead researcher. To do this you will need to let your care co-ordinator know that you would like to be referred. Once your referral has been received you will receive an appointment to meet with the lead researcher where you will have an opportunity to ask any questions and have a look at the questionnaires before agreeing to be involved.
You will then be asked to complete a consent form.
This confirms by signing the Consent form that you agree to be part of the study and that you agree for your information to be published as part of a Clinical Doctorate Thesis.

What if I change my mind about being involved in the study?

You can change your mind at any point during the study and the information that you have supplied up to that point will be withdrawn from the study.

Appendix E Structured interview Consent Form

Consent Form

Full title of Project: Is there a connection between attachment difficulties, problems with intimacy and Obsessive Compulsive Disorder. If so what is it?

Name, position and contact address of Chief Investigator

Beverley Mears
Senior psychotherapist
Secondary Care Psychological Therapy Service
Address
Telephone Number

		Please Initial Box
1.	I confirm that I have read and understand the information sheet dated xxx (version xx) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my medical care or legal rights being affected.	☐
3.	I agree to my identifiable data being stored for a period of 1year and my anonymised data being stored until 2017	☐
4.	I agree the use of anonymised quotes in publications	☐
5.	I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Name of Chief Investigator	Date	Signature

Appendix F Qualitative Study Consent Form

Secondary Care Psychological Therapies Service

Address Removed

Consent Form

Full title of Project: Is there a connection between attachment difficulties, problems with intimacy and Obsessive Compulsive Disorder. If so what is it?

Name, position and contact address of Chief Investigator

Beverley Mears
Senior psychotherapist
Secondary Care Psychological Therapy Service
Address
Telephone number

Please Initial Box

1 I confirm that I have read and understand the information sheet dated xxx (version xx) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my medical care or legal rights being affected. ☐

3. I agree to the psychotherapy session being recorded ☐

4. I agree to my identifiable data being stored for a period of 1year and my anonymised data being stored until 2017 ☐

5. I agree the use of anonymised quotes in publications ☐

6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Chief Investigator	Date	Signature

Appendix G Demographic Questionnaire

Patient Demographic Form		
Gender	Male □	Female □
Age	18-24 25-34 35-44 45-54 55-64 65-74	□ □ □ □ □ □
Ethnicity	White -British White - Irish White - Any other background Mixed – white &black Caribbean Mixed – White & black Africa Mixed – White & Asian Mixed – Any other background Asian or Asian British- Indian Asian or Asian British – Pakistani Asian or Asian British – Bangladeshi Asian or Asian British – Any other background Black or Black British – Caribbean Black or Black British – African Black or Black British – Any other background	□ □ □ □ □ □ □ □ □ □ □ □ □ □
Sexual Orientation	Heterosexual or Straight Gay or Lesbian Bisexual Other Prefer not to say	□ □ □ □ □
Marital Status	Single, never married Married or domestic partnership Widowed Divorced Separated	□ □ □ □ □
Parents Information Are your parents:		
Married	Yes □	No □

Co-habiting	Yes □	No □
Still together	Yes □	No □
Personal History		
Educational level completed	Secondary School	No qualification □ Up to GCE Level □ Up to A Level □
	College Qualification	□
	Trade/Technical/Vocational	□
	Bachelor's Degree	□
	Master's Degree	□
	Doctorate Degree	□
Childhood Abuse	Physical Psychological Sexual	Yes □ No □ Yes □ No □ Yes □ No □
Deaths experienced in childhood	Yes □ No □	*Please give details*

Appendix H The Obsessive Compulsive Inventory (OCI) (Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., & Amir, N. 1998)

Obsessive-compulsive Inventory (OCI) (Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., & Amir, N. 1998)

Obsessive-Compulsive Inventory (OCI)

Client ID_____ Date_____ Stage Completed _____

Please read each statement and select a number 0, 1, 2, 3 or 4 that best describes how much that experience has distressed or bothered you during the past month. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a health professional.

0 = Not at all 1 = A little 2 = Moderately 3 = A lot 4 = Extremely

1	Unpleasant thoughts come into my mind against my will and I cannot get rid of them	1 2 3 4
2	I think contact with bodily secretions (sweat, saliva, blood, urine, etc.) may contaminate my clothes or somehow harm me	1 2 3 4
3	I ask people to repeat things to me several times, even though I understood them the first time	1 2 3 4
4	I wash and clean obsessively	1 2 3 4
5	I have to review mentally past events, conversations and actions to make sure that I didn't do something wrong	1 2 3 4
6	I have saved up so many things that they get in the way	1 2 3 4
7	I check things more often than necessary	1 2 3 4
8	I avoid using public toilets because I am afraid of disease or contamination	1 2 3 4
9	I repeatedly check doors, windows, drawers etc	1 2 3 4

10	I repeatedly check gas / water taps / light switches after turning them off	1 2 3 4
11	I collect things I don't need	1 2 3 4
12	I have thoughts of having hurt someone without knowing it	1 2 3 4
13	I have thoughts that I might want to harm myself or others	1 2 3 4
14	I get upset if objects are not arranged properly	1 2 3 4
15	I feel obliged to follow a particular order of dressing, undressing and washing myself	1 2 3 4
16	I feel compelled to count while I'm doing things	1 2 3 4
17	I am afraid of impulsively doing harmful or embarrassing things	1 2 3 4
18	I need to pray to cancel bad thoughts or feelings	1 2 3 4
19	I need to keep checking forms or other things I have written	1 2 3 4
20	I get upset at the sight of knives, scissors or other sharp objects in case I lose control with them	1 2 3 4
21	I am obsessively concerned about cleanliness	1 2 3 4
22	I find it difficult to touch an object when I know it has been touched by strangers or certain people	1 2 3 4
23	I need things to be arranged in a particular order	1 2 3 4
24	I get behind in my work because I repeat things over and over again	1 2 3 4
25	I feel I have to repeat certain numbers	1 2 3 4
26	After doing something carefully, I still have the impression I haven't finished it	1 2 3 4
27	I find it difficult to touch rubbish or dirty things	1 2 3 4
28	I find it difficult to control my thoughts	1 2 3 4
29	I have to do things over and over again until it feels right	1 2 3 4

30	I am upset by unpleasant thoughts that come into my mind against my will	1 2 3 4
31	Before going to sleep I have to do certain things in a certain way	1 2 3 4
32	I go back to places to make sure that I haven't harmed anyone	1 2 3 4
33	I frequently get nasty thoughts and have difficulty getting rid of them	1 2 3 4
34	I avoid throwing things away because I am afraid I might need them later	1 2 3 4
35	I get upset if others have changed the way I arrange things	1 2 3 4
36	I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions	1 2 3 4
37	After I have done things, I have persistent doubts about whether I really did them	1 2 3 4
38	I sometimes have to wash or clean myself simply because I feel contaminated	1 2 3 4
39	I feel that there are good and bad numbers	1 2 3 4
40	I repeatedly check anything that might cause a fire	1 2 3 4
41	Even when I do something very carefully I feel that it is not quite right	1 2 3 4
42	I wash my hands more often, or far longer than necessary	1 2 3 4

Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., and Amir, N. (1998). The validation of a new Obsessive Compulsive Disorder scale: The Obsessive-Compulsive Inventory. Psychological Assessment, 10(3), 206-214.

Checking	
Doubting	
Ordering	
Obsessions	
Hoarding	
Neutralising	
Mean OCI distress	
Total OCI Score	

Appendices

Appendix I The Sexuality Scale (SS), (Snell & Papini 1989)

Sexuality Scale William. E. Snell., JR.., *Southeast Missouri State University*
Version 1.2 29.05.15

Sexuality Scale

Patient ID _____

Instructions: The statements listed below describe certain attitudes towards human sexuality which different people may have. As such there are no right or wrong answers, only personal responses. For each item you will be asked to indicate how much you agree or disagree with the statements listed in that item. Use the following scale to provide your responses:

(A)	(B)	(C)	(D)	(E)
Agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Disagree

1	I am a good sexual partner	A	B	C	D	E
2	I am depressed about sexual aspects of my life	A	B	C	D	E
3	I think about sex all of the time	A	B	C	D	E
4	I would rate my sex skills quite highly	A	B	C	D	E
5	I feel good about my sexuality (R)	A	B	C	D	E
6	I think about sex more than anything else	A	B	C	D	E
7	I am better at sex than most people	A	B	C	D	E
8	I am disappointed about the quality of my sex life	A	B	C	D	E
9	I don't daydream about sexual situations(R)	A	B	C	D	E
10	I sometimes have doubts about my sexual competence. (R)	A	B	C	D	E
11	Thinking about sex makes me happy	A	B	C	D	E
12	I tend to be preoccupied with sex	A	B	C	D	E
13	I am not very confident in sexual encounters	A	B	C	D	E
14	I derive pleasure and enjoyment from sex	A	B	C	D	E
15	I am constantly thinking about having sex	A	B	C	D	E
16	I think of myself as a very good sexual partner	A	B	C	D	E
17	I feel down about my sex life	A	B	C	D	E
18	I think about sex a great deal of the time	A	B	C	D	E
19	I would rate myself low as a sexual partner (R)	A	B	C	D	E
20	I feel unhappy about my sexual relationships (R)	A	B	C	D	E
21	I seldom think about sex (R)	A	B	C	D	E
22	I am confident about myself as a sexual partner	A	B	C	D	E
23	I feel pleased with my sex life (R)	A	B	C	D	E
24	I hardly ever fantasise about having sex (R)	A	B	C	D	E
25	I am not very confident about my sexual skill (R)	A	B	C	D	E
26	I feel sad when I think about my sexual experiences	A	B	C	D	E
27	I probably think about sex less often than most	A	B	C	D	E

	people (R)	
28	I sometimes doubt my sexual competence (R)	A B C D E
29	I am not discouraged about sex (R)	A B C D E
30	I don't think about sex very often (R)	A B C D E

KLEIN.M. 1930. The Improtance of Symbol-Formation in the Deveopment of the Ego. *The Internalional Journal of Psycho-Analysis*, 24-39.