Psychodynamic Perspective of Sexual Obsessions in Obsessive-Compulsive Disorder

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Abstract

Obsessive-compulsive disorder (OCD) is a disorder that is characterized by the presence of obsessions and compulsions. OCD can occur in a wide range of subtypes, which may include sexual OCD, i.e., the occurrence of intrusive sexual thoughts. People with sexual OCD may experience unwanted obsessive sexual thoughts about a family member, dead or inanimate objects, animals, God, or children, which can range from mild to severe levels of occurrence. The psychodynamic perspective on OCD suggests that the content of obsessive thinking is commonly drawn from primitivized sexuality and aggression. It further suggests that in the absence of key relationships that include emotional proximity, mirroring and containment, and attunement, a child experiences a void-like state. Consequently, the anxiety that arises in the child leads to a form of liveliness in a “dead” inner world. However, it occurs out of a sense of abandonment and loss of good objects, and ultimately out of fear of annihilation. As a result, the child resorts to maladaptive defense mechanisms. The study attempts to explore the adverse early childhood experiences such as parental neglect, mother–father conflict, and lack of parental love and care leading to fixation in psychosexual stages of development, which further leads to the adoption of maladaptive defense mechanisms that in turn further contribute to the development of obsessional personality traits. This study aims to explain the psychodynamic perspective on the emergence of sexual obsessions by proceeding with a case study approach by taking a diagnosed case of OCD. A comprehensive psychodiagnostic assessment was conducted with the help of Draw-a-Person Test, Thematic Apperception Test, Rotter’s Incomplete Sentence Blank, and Million’s Comprehensive Multiaxial Inventory. The analysis of the assessment protocol revealed a strong relationship between the defense mechanism, personality traits, and the development of obsessive symptoms.

Keywords
Childhood experiences, maladaptive defense mechanisms, sexual obsessions

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Introduction

Obsessive-compulsive disorder (OCD) is a disorder that is characterized by the presence of obsessions and compulsions. Obsessions are recurrent and persistent unwanted thoughts, urges, or images that are intrusive in nature and cause anxiety and distress. Compulsions comprise repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession. There are continuous attempts by the individual to suppress or ignore such thoughts and urges or the individual tries to neutralize them by some other thought or by performing an action (i.e., a compulsion). Such behaviors are always aimed at reducing or preventing anxiety and distress.¹ However, these mental acts or behaviors are excessive in nature and are not realistically connected to what they aim to prevent or neutralize. These obsessions and compulsions are time-consuming and occupy most of the time of the day and cause clinically significant distress in personal, social, occupational, and other important areas of functioning.

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The worldwide lifetime prevalence rate of OCD ranges from 1.1% to 1.8%. OCD can occur in a wide range of subtypes, which may include sexual OCD, i.e., the occurrence of intrusive sexual thoughts. People with sexual OCD may experience unwanted obsessive sexual thoughts about a family member, dead or inanimate objects, animals, God, or children that can range from mild to severe. Researchers suggest that approximately 24% of people with OCD have these intrusive sexual thoughts. However, these figures may under-represent the actual percentage of people suffering from sexual OCD because of the unawareness, reluctance, shame, and fear to admit this as well as because of the misconception of sexual obsessions as fantasies. However, they both differ in their very nature as fantasies provide pleasure and sexual obsessions include unwanted repetitive thoughts that are intrusive in nature and there are continuous attempts by the individual to get rid of them. These efforts to suppress obsessions generally fail and paradoxically increase obsessive ideation. This phenomenon is referred to as the thought suppression paradox.

Sexual obsessions are autogenous obsessions, i.e., they appear by themselves, are highly unrealistic and averse, and may be perceived as dangerous. A person with a sexual OCD may be afraid of the meaning carried by sexual thoughts (for instance, "if I have these sexual thoughts, it means that I am a bad person"). Sexual ideation or thoughts in OCD are extremely upsetting and unpleasant. The individual with sexual OCD never wants to act out on the sexual thoughts instead the person wants to stop thinking about it. These thoughts induce distress and a high level of guilt as well as significantly disrupt everyday functioning.

Compulsions in terms of sexual OCD may include neutralizing behaviors such as checking the level of excitement (e.g., checking body sensations in situations that may activate obsessions, by contracting muscles; maintaining a sufficient physical distance from the person/object or others to ensure that inappropriate behavior does not occur, e.g., touching), or performing mental actions (e.g., praying). There are also hidden attempts to neutralize or suppress these sexual obsessions. Sexually oriented OCD is generally characterized by unwanted intrusive sexual thoughts and ego-dystonic sexual content, which may include thoughts about sexual activity with family members, child abuse, fears or thoughts related to sexual orientation, inappropriate sexual activity (e.g., with animals, children, or inanimate objects), and aggressive sexual behaviors.

**Case Presentation**

The patient, Mr F, 26 years old, male, unmarried, employed (sales manager), R/O Noida, Uttar Pradesh, belonging to Upper SES, nuclear, urban Hindu family, visited clinical psychology OPD, Gautam Buddha University, with the complaints of unwanted sexual thoughts about family members, constant irritability, spending hours on these unwanted thoughts that led to the disruptions in everyday functioning, feelings of guilt and trouble in maintaining and establishing healthy relationships with insidious onset, continuous course, since last 2 years, having no significant family history of any psychiatric illness or of any organic involvement, loss of consciousness, irrational fear, suspiciousness or any psychotic symptoms, and also having significant findings on mental status examination of sexual obsessions with feelings of guilt with an insight of grade level 5.

The patient reported having sexual thoughts about his mother and sister which were intrusive, recurrent, and distressing to him. In order to stop these unwanted thoughts, the patient tried every possible way he could think to distract his mind but nothing really helped reduce those unwanted thoughts. The patient tried to avoid the experience of emotions associated with his unwanted thoughts using affirmations to overcome the unwanted distressing thoughts. The patient complains of not having any power to refrain himself from fanaticizing about his mother in an explicit erotic manner, which further disturbed the patient and made him feel anxious most of the days, furthermore, leading him to avoid any situation related to his intrusive sexual thoughts including avoiding to sit in the same room alone with his mother and performing mental rituals to replace unacceptable sexual thoughts. The patient reported extreme fear of getting sexually attracted to his mother which made him feel more guilty. These disturbances occurred throughout the day on a regular basis. His personal, social, and occupational functioning was hampered because of these unwanted sexual thoughts. He did not want to get married, or get into any relationship with anybody, felt scared to go out to parties as it may act as a sexual trigger for him, and could not focus on his work. These disturbances have been affecting his daily life routine with the presence of feelings of guilt, frustration, loneliness, and loss of appetite along with disturbances in sleep. It became very difficult for him to subside his irritation and anxiety resulting from these unwanted thoughts.

The patient was ruled out for having any comorbid neuropsychiatric condition and also no history of any past psychiatric illness or any major medical condition was found to be associated with the patient.

**Early Experiences**

He was a rigid, stubborn, and indecisive child. He used to wait for his father to play with him but when was denied his father’s time, he often showed temper tantrums and refused to play with anyone else. The patient used to often worry about his parents’ fights and conflicts. His childhood was deprived of fatherly love and care as his father never used to spend time or play with him. As a child, he had always sought parental love, care, and support because his parents were busy with their own personal conflicts and did not have time for him. The
parents of the patient got separated when he was 17 years old; his father moved abroad and married someone else there. The patient was closely attached to his mother. The patient belonged to upper socioeconomic status, Hindu, and a nuclear family currently residing in Noida, Uttar Pradesh. The patient is the elder sibling of the two and his younger sister is in college. There is no significant history of any medical or psychiatric illness in the family. The family's current social situation is good. They have a healthy communication pattern and the patient supported his mother and sister and takes good care of their well-being since his father left them.

The patient’s relationship with his mother is nurturing and caring while that with his father is distant. He had few close friends. He likes to spend his leisure time cooking, singing, traveling, and watching web series. His attitude toward others is caring and helpful. The patient has always been an opinionated person and wanted to have the best of everything like the best car, best office, etc. The patient has been an anxious and introverted type of person. The patient was always fearful of making mistakes and prefers to do things in a structured way. The predominant mood was euthymic. He was a self-confident and ambitious person with high self-esteem. He was dedicated to his work and responsibilities and has been respectful toward other religious beliefs and morals.

Psychodiagnostic Assessments

Having been diagnosed with OCD with sexual obsessions, the psychodiagnostic assessment of the patient was planned, which included both projective and objective psychological tests. The projective assessment included administration of the Draw-a-Person Test (DAPT), Rotter’s Incomplete Sentence Blank, and Thematic Apperception Test (TAT). However, the objective method included Bender Gestalt Test-II (BGT-II) and Millon Clinical Multiaxial Inventory-III.

The purpose of conducting a psychodiagnostic assessment was to elicit the psychosocial functioning of the patient. The purpose of conducting BGT-II was to measure visual-motor integration skills and to rule out organicity or any neurological condition. DAPT was conducted to assess the intellectual ability and personality traits of the patient. The purpose of conducting projective techniques was to explore the dynamics of the patient’s personality by gathering information on both: the patient’s perceptual-cognitive world and inner fantasy world. It was used as a basis for eliciting associations that are revealing of disruptive personality development. Millon Clinical Multiaxial Inventory-III was used to understand the psychopathology of the patient and to assess information on the personality traits, inclusive of particular specific psychiatric disorders outlined in DSM-5.

Results

Cognitive Functioning

The cognitive ability of the patient was assessed using BGT-II and it was observed that his motor and perceptual ability was within the normal percentile range, which further indicates no involvement of any organicity in the patient. The test results further indicate adequate visual-motor performance (accurate interpretation of input information), adequate execution abilities (accurate fine-motor response output), and adequate central processing abilities (accurate memory storage and retrieval systems). The patient was able to make proper designs with respect to space, size, and organization, and there were no changes in the gestalt form and no distortions were observed. Thus, the patient’s planning, organizational, and constructional ability was found to be adequate.

The findings on the TAT protocol suggested a structured, real, and complete plot of the stories. The hero identification was found to be adequate. TAT shows average productivity and mental process. The stories are relevant and with a definite end. The profile is indicating average intellectual functioning. Imagination was found to be excellent and language used in writing stories was well framed with grammatically correct sentences.

Harris suggested that the drawings are representative of the intellectual maturity and cognitive functioning of a person. The analysis of the presence of the various aspects of the patient’s drawings on the DAPT such as the gross detailing that includes head, legs, arms, shoulder, etc.; attachments of different body parts at the correct points, detailing of the head including eyes, nose, mouth, lips, etc.; and the complete body profile without any error indicates adequate cognitive functioning of the patient.

Conflicts/Intrapersonal and Interpersonal Dynamics

The patient’s completions on Rotter’s Incomplete Sentence Blank (RISB) provide a picture of the strong relationship with his mother. However, it shows an unhealthy relationship with his father. The analysis of the entire record of sentence blank indicates the presence of many conflicts within the patient’s family but there is still a good bonding between the patient and his mother, although the patient’s completions also reflect his regret to think about his mother in wrong ways. The patient showed a preference to stay aloof and dissatisfaction with his current social, family, and love life. The patient’s completions also reflect his fear of rejection by others. Similar findings were observed on DAPT drawings which indicate the presence of rejection by the paternal figure.

The patient’s stories on TAT reveal that he perceives his environment to be helpless, lacking assistance and support.
and fatherly love and care, there is a sense of loss over an extended period of time, rejection, and lastly, his affections are engaged by a seducer. Murray explained that needs (readiness to respond in a certain way) when interacting with the environmental factors play a significant role in determining one’s personality and behavior in interpersonal settings. On TAT protocol, the prominent needs reflected in stories were: Sex, Sentience (erotic), Nurturance, Abasement, Excitance, Succorance, Rejection, Dejection, and Autonomy (Asocial). The prominent environmental forces (presses) that are found to be impacting the patient’s personality and behavior include (P sex, P lack, P loss, P rejection, P succorance, and P affiliation [emotional]). The patient’s feeling state was found to be dejection, distrust, rejection, succorance, and affiliation (emotional). The prominent environmental forces were: Sex, Sentience (erotic), Nurturance, Abasement, Excitance, and Rejection. The patient’s feeling state was found to be dejection, distrust, rejection, succorance, and affiliation (emotional).

According to the psychoanalytic perspective, our personality develops from a conflict between the two forces: biological aggressive and pleasure-seeking drives versus internal (socialized) control over these drives. One’s personality is the result of how the individual is balancing these two competing forces.

Major conflicts that were found in this case were:

1. **Id vs. Superego:** The unconscious id contains one’s primitive urges or drives, and is present from birth. It works on the pleasure principle and directs or controls impulses for hunger, thirst, and sex seeking immediate gratification. The superego, on the other hand, works on the moral principle and acts as our conscience. It acts as a moral compass that tells us how one should behave, what is right or wrong, and judges one’s behavior, leading to feelings of pride or guilt. In the above-presented case, there is a presence of constant conflict between the patient’s id and superego about what he finds pleasurable and what is morally wrong. His id is playing a role in directing his sexual thoughts about his mother and his superego is acting as a barrier against those urges leading to feelings of guilt and disgust by making him realize what is morally appropriate or inappropriate.

2. **Autonomy vs. Succorance:** The patient’s stories on TAT depict a conflict between his need to be dependent and seeking love and protection contrary to seeking independence and to remain unattached or avoiding any close relationships. Succorance can be explained as a need to be loved, protected, and cared for, in which the patient expresses his desire to be dependent and helpless. It is clearly depicted that he craves affection or tenderness and wished to have a close relationship. Autonomy, on the other hand, can be defined as the need to become independent and avoid any restraint. He expresses his desire to be unattached from any feeling or close relationship. He wished to break all the moral and social standards and depicts refusal to comply with any social rules or norms and shows resistance toward coercion.

**Use of Defenses**

Defense mechanisms are the mental processes that occur unconsciousness and enable the mind to produce compromise solutions to conflicts that are difficult to resolve. It generally involves concealing from one’s self-internal drives or thoughts and feelings that may threaten to lower self-esteem or produce anxiety and distress. Defense mechanisms if used excessively can lead to psychopathology. Freud explained that OCD symptoms occur as a result of the unsuccessful functioning of defense mechanisms. Major defenses used by the patient were:

1. **Repression:** Involves the withdrawal of an unwanted affect, idea, or desire from consciousness by repressing it or pushing it down into the unconscious part of the mind. Repressed emotions stay hidden under the surface and play a major role in impacting different aspects of a person’s life including relationships. In the above-presented case, the patient has used this defense mechanism to repress his negative childhood memories and emotions associated with those thoughts and feelings, which further impacted his interpersonal relationships in adult life. An example of the implementation of this defense mechanism was also depicted in the TAT stories written by the patient: “This child was not loved by his father during his childhood. He used to feel very scared from his father. He used to shout at him a lot.” “This person thinks that any marriage or relationships are not long-lasting, therefore he doesn’t believe in relationships.”

2. **Displacement:** Involves redirecting one’s emotional burden or emotional reaction from one entity to a less-threatening entity. By using this defense mechanism, one deflects a negative emotion to a less-threatening recipient from its original source, taking out feelings, frustrations, and impulses on objects or people that are less threatening. An example of the implementation of this defense mechanism was also depicted in the TAT stories written by the patient: “This boy hates his father and he is feeling like hitting him but he is scared that his mother will get angry if he will say anything to him so he breaks his favorite vase and now his mother is angry with him.”

3. **Undoing:** By using this defense mechanism, one attempts to avoid conscious awareness of distressing impulses or thoughts by thinking or acting in opposite ways to revert (“make un-happen”) those thoughts or impulses. It is used by the patient as a way to
psychologically defend oneself against those distressing thoughts. An example of the implementation of this defense mechanism was also depicted in the TAT stories written by the patient: “Last night this boy thinks about his mom in dirty ways because of which he wants to now overcome that and that is why he is taking caring of her, reminding her that how much he respected her” (Trying to undo/remove the unhealthy thoughts by engaging in contrary behavior).

4. **Isolation of Affect**: Involves separating ideas or feelings from the thoughts that are anxiety-provoking. The patient tries to avoid the experience of emotion associated with his thoughts about his mother. In distinguishing an emotion in this way, an attempt is made by him to protect the ego from anxieties caused by these sexual thoughts. An example of the implementation of this defense mechanism was also depicted in the TAT stories written by the patient: “This boy slept with his mom and now he is sitting with her in the same room, he don’t know what to say, he decided that he will behave normally as if nothing happened or he didn’t do it on purpose. He will never talk about it again.”

Other defense mechanism used by the patient includes:

- **Reaction Formation**: Includes replacing one’s initial unwanted impulse toward an idea or situation with the opposite impulse. In this, one unconsciously replaces an anxiety-provoking or unwanted impulse.

- **Regression**: Involves returning to early stages of development and abandoned forms of gratification belonging to them. Environmental factors or stressors may lead to the occurrence of regression at later stages in life.

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**Psychopathology**

The findings suggest that the patient is rigid, stubborn, and indecisive. The patient has a reliable self-image, he sees himself as devoted to work, meticulous (showing great attention to detail), and efficient. The patient is fearful of error or misjudgment and hence overvalues perfectionism and prudence. The test findings are also suggestive of the patient personality patterns as cognitively expansive, i.e., he has an undisciplined imagination and exhibits a preoccupation with immature and self-glorifying fantasies of beauty or love. He is minimally constrained by objective reality and prefers to take liberties with the facts.

The patient enjoys the image of attracting acquaintances by physical appearance and by pursuing a pleasure-oriented life. He is seductively exhibitionistic (deriving sexual gratification from fantasies). The patient personality patterns also reflect a liking for momentary excitement, fleeting adventures, and shortsighted hedonism. The findings also suggest that the patient has “pernicious representations,” i.e., internalized representations of the past that are distinguished by early relationships that have generated strongly driven aggressive energies and malicious attitudes as well as by a contrasting paucity of sentimental memories, tender affects, internal conflicts, and shame and guilt feelings. Patient personality patterns also indicate chaotic internalized representations that consist of a piecemeal jumble of early relationships and affects, random drives and impulses, and uncoordinated channels of regulation that may lead to binding tensions, accommodating needs, and mediating conflicts (Figure 1).

**Discussion**

Obsessive thoughts involve a compulsive and repetitive mental preoccupation with images, ideas, or impulses that the person finds highly disturbing and distressing. Generally, the individual experience intrusive distressing thoughts that interfere with his or her daily living and they may attempt to control these by further thoughts or actions which seek to neutralize initial distressing ones. Psychodynamic perspective on OCD suggested that the content of obsessive thinking is commonly drawn from primitivized sexuality and aggression. The object of aggression is often a parent, spouse, or child. It is very important to understand the conscious and unconscious meanings and functions of OCD symptoms. Childhood experiences and conflicts shape one’s overall personality as an adult. Psychodynamic perspective on OCD suggests that in the absence of key relational processes, including emotional proximity, mirroring and containment, and attunement, the child experiences a void-like state. Consequently, the anxiety that arises in the child leads to a
form of liveliness in a “dead” inner world. However, it occurs out of a sense of abandonment and loss of good objects and ultimately out of fear of annihilation. As a result, the child resorts to maladaptive defense mechanisms. For example, in the above-presented case, adverse early childhood experiences such as parental neglect, mother–father conflict, and lack of parental love and care lead to fixation in psychosexual stages of development, which further leads to the adoption of maladaptive defense mechanisms. Maladaptive defense mechanism (i.e., reaction formation) plays a role in the development of obsessional personality traits. Freud suggested that our childhood events and experiences influence how one’s personality is shaped as an adult. Anxiety that originates from childhood traumatic experiences in the past gets hidden from the consciousness and later may cause problems in adulthood thus playing a role in the development of neurosis.

Freud as well as many contemporary psychoanalysts suggested that defense mechanisms play a specific function of protecting the self from conflicts, anxiety, shame, loss of self-esteem, and other negative thoughts and unacceptable feelings. According to the psychoanalytic perspective, personality styles and organizations are strongly related to the use of specific defense mechanism patterns. For example, studies suggested that the neurotic organization of personality is characterized by persistent use of mature and neurotic defense mechanisms, identity integration (object constancy), and a conserved capacity for reality testing. There are many studies on the use of defense mechanisms that suggested that excessive use of immature defense mechanisms can be a risk factor for the occurrence of different forms of psychopathology. Thus, in the above-mentioned case report, excessive use of immature defense mechanisms led to the development of obsessional personality traits.

According to Sigmund Freud, obsessions are psychogenically related. Psychodynamic theory explains that OCD occurs because of a defensive regression to the early stages of development with the use of maladaptive defense mechanisms such as isolation of affect, undoing, displacement, and reaction formation. Freud explained that “obsessional neurosis” emerges from repressed libidinal impulses. OCD symptoms result because of repressed mental processes, wishes, and desires, which went out via substitution or conversion. Thus, intense harmful effects are displaced upon alternative less harmful representations.

Psychodynamic theory explains that the person with OCD uses isolation of affect, in which ego removes affect from the anxiety-provoking idea. Thus, the idea gets weakened but still remains in the consciousness. However, the affect becomes free and by using symbolic associations, attaches itself to other neutral ideas. Hence, such neutral ideas or thoughts become anxiety-provoking and in turn lead to the formation of obsessions. The defense mechanism of undoing leads to the formation of compulsions in order to prevent feared consequences of obsessive thoughts ideas or impulses. Displacement is used as a psychological defense and the person with OCD redirects his or her negative emotion from the original source to the less threatening stimuli. For example, in the above-discussed case, the patient uses the defense of displaced aggression from his father to less harmful effects.

Conclusion

OCD is characterized by the presence of recurrent intrusive thoughts, ideas or images, and repetitive compulsive rituals or behaviors. The case of Mr F is a classic example of how psychodynamic perspective plays a significant role in understanding the development of the obsessive-compulsive disorder. This case helps in understanding that one’s personality is firmly rooted in their childhood experiences and is influenced by one’s environment and family relationships. This case also sheds light on the fact that early adverse childhood experiences lead to the fixation in psychosexual stages of development. These factors when combined with faulty or maladaptive coping mechanisms lead to the development of dysfunctional or distressing thought patterns. Some of the maladaptive defense mechanisms that are associated with the development of OCD include isolation of affect, undoing, displacement, and regression. Thus, for developing the proper understanding of the patient’s psychopathology, it is important to recognize how early experiences of attachment figures affect one’s relation to and experience of the present. It is important to explore the relation between the past and present, understanding the ways in which the past sheds light on current psychological difficulties.

Authors’ Contribution

SC is the corresponding author of this article. All the work from the conception, data collection, data analysis and interpretation, drafting the article, critical revision and final approval of the article was done under the supervision and guidance of coauthors, APS and AV.

Statement of Ethics

Ethical approval was taken from the departmental ethics committee and all procedures involving human participants were followed and approved by the Head of the Department of Psychology and Mental Health and associated team members. However, there is no local or regional body associated with the university.
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