Sexuality in the Obsessional Neuroses

The sexual life and difficulties of the obsessional patient embrace a range of behaviors including mechanization of sex, impotence, premature ejaculation, retarded orgasm, and the compulsive genital activities. These difficulties are functions of the obsessional character structure and of the cognitive disorders which are their dynamic core. This essay will explore these major symptomatic expressions of obsessional sexuality and relate them to the dynamics of the cognitive disorders. The importance of shame and the special nature of obsessional dependency will be examined.

In previous papers (Barnett, 1966a, 1966b, 1968) I developed the thesis that the basic fault of obsessional living is a cognitive disorder in which interpersonal inference-making is disturbed in order to prevent comprehension of specific cognitive configurations that threaten self-esteem. I have observed that cognition may be regarded as a system of experiential knowing that integrates apprehended modes of knowing organized in sensate, affective states, and the comprehended mode of knowing organized in syntactic, linguistic terms as thought. Cognition, in this view, is considered as encompassing both affect and thought in a constantly interacting system. Interference of any kind with the balanced interchange between affect and thought creates defects in understanding of experience. In the obsessional neuroses, this interference results from the use of a mechanism I call "implosion of affects." In this mechanism there is an internal eruption of primitive, undifferentiated affects that flood the cognitive system, jamming and disintegrating the inferential processes that are necessary to organize the implications of ongoing interpersonal experience. This occurs especially in historically determined areas where such comprehension would be threatening to self-esteem. Implosion helps the obsessional patient maintain innocence in specific areas by using primitive affects to restrict inference-making and comprehension of experience.

These characteristic disturbances of knowing are central to an un-
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derstanding of the obsessional patient's sexual life. Stylistically and symptomatically, his sexual life mirrors this characterological template. Since sex involves intimacy, it is often an area of especially poignant conflict for the obsessional person. I shall attempt to show why this is so and to relate the sexual developments in the life of the obsessional to this character organization.

The obsessional way of life is largely organized to meet the historical dilemma created by the hypocrisy and ambiguity characteristic of the obsessional's early family situation. The self-system of the obsessional develops in a climate of hostility, rejection, and power struggle hidden beneath a façade of loving care and concern (Sullivan, 1956). In lieu of warmth and acceptance, he has been the object of overprotective and restrictive demands. Parental approval was predicated on the degree of the child's conformity to parental needs and expectations, which disregarded or exploited the needs, feelings, and capabilities of the child. He is caught, therefore, in the paradox that he is most approved when he is least himself or for himself. Faced with this deceptive definition of love, he can maintain the illusion of being loved, accepted, and therefore worthwhile as a person only if he accepts the parents' explicit behavior and avowed concern. Were he to draw inferences, that is, to examine what is implicit in the parental behavior, he would be threatened with the knowledge that he is unloved and rejected, and with the conclusion that he must be insignificant, worthless, and bad.

The explicit and the literal thus become the guidelines to what appears to him to be self-esteem, whereas the implicit and inferred come to represent the self-contempt and self-loathing that constantly lurk beneath his façade of perfection and achievement. This dilemma leads to the pervasive unwillingness to know about himself and the impact he makes on others or they on him that I feel characterizes the obsessional's cognitive system, and which I call "systems of innocence." By creating disturbances in inference-making which might organize the implicit meaning of interpersonal events, he avoids comprehension of events that threaten self-esteem and maintains the childhood systems of innocence that accept the infallibility of the parents. He maintains this innocence by the mechanism of implosion of affects.

The maintenance of these systems of innocence and the avoidance of the implications of interpersonal transactions result in the develop-
ment of pervasive feelings of shame and concomitant fears of exposure. Shame, in my clinical experience, is an affective tone of considerable significance to the obsessional way of life. It is the specter of his own self-loathing, always present to confine him to the known and the literal and to restrict his behavior to the narrow boundaries created originally by his family’s limited and conditional acceptance of him, and perpetuated by his development of a self-system organized around these private conceptions of good and bad, right and wrong. Convinced, as he is, that he is bad, insignificant, and unworthy of love, he cannot face those needs and feelings that were exploited or frustrated in his early life experience and that came to be elaborated as defenses against his underlying lack of self-esteem. His dependent cravings, his infantile narcissism, his anger and power needs, all verify his fears of his unacceptability, exemplify his emotional vulnerability, and intensify his sense of shame and his fears of exposure, of being revealed to himself and others. Worst of all, he feels disgraced by his own capitulation to the demands that compromised him and avoids knowledge of the shameful exposure of his craven surrender of himself, and of the needs that drove him to it.

For the obsessional, the more intimate the interpersonal experience, the more pronounced is the sense of shame and the more severe are the fears of exposure. Intimacy, by its very nature, presupposes knowledge and demands exposure. But in the experience of the obsessional, the closer the relationship, the more he feels his needs and the more vulnerable he is to censure and exploitation of these needs, and to shame for his self-compromising efforts at satisfaction. Intimacy thus poses a special problem for the obsessional. The area of sex is particularly dangerous, especially when it is not casual and when it is related to a meaningful and intimate interpersonal situation. The sexual situation is highly revealing of needs, impulses, and attitudes about self and others. It is largely dependent on the ability to assert one’s wants directly. Ideally, sex evokes spontaneous behavior, thoughts, and feelings that are expressive and abandoned. In that it demands self-exposure and self-expressiveness, which are restricted by the dynamics of the obsessional’s need to maintain innocence, sex is threatening. In that a rehearsed performance may not dependably suffice for an interpersonal situation which, as Ruesch (1951) pointed out, by definition demands responsiveness to the partner’s response, sex is doubly threatening. A solution often utilized by the obsessional is to
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separate sexual and emotional needs and to employ massive guarding techniques in regard to his emotional needs, while he pursues a narrow spectrum of largely ritualized and stereotyped sexual responses that can safely be adapted to an intimate interpersonal situation.

Stylistically, therefore, he presents the picture of a mechanized sexual performance that is competent, stereotyped, unspontaneous, and unimaginative. This mechanized performance derives, on the one hand, from the inhibition and restriction of action to minimize the risks of shame and self-exposure and, on the other, from the concretization and literalization of experience created by the mechanism of implosion. The mechanized solution is unsatisfactory because the obsessional's comprehension of himself and his partner is seriously impaired by the mechanism of affective implosion, which prevents inference-making. He remains unaware of his impact on his partner and substitutes stereotyped transference assumptions in the place of active, ongoing inferences that might help him to understand her. He is even in the dark concerning his own intentions, for, failing to infer the operational premises of his own behavior, he is separated from his intentionality and forever bemused about the apparent gulf between his stated intent and the effect he seems to have on others.

Simultaneously, he creates what I call the "secret life" of the obsessional. Isolating those aspects of his affective life that are strongly connected with shame, such as aggressive impulses or the need for nurturance, he organizes them into a secret life of fantasy, thought, and feeling, which is kept divorced from his intimate interpersonal field. This becomes an encapsulated system, existing in varying degrees of dissociation, depending on the extent of pathology present. Clinically, I find it present to some degree in all obsessional patients, reflecting and reinforcing the experience of shame and its determinants. It varies from completely organized fantasy lives to the presence of occasional thoughts and feelings. It may exist as conscious obsessional ruminations or in the form of dissociated systems reflected only by the "brown study" states described by Sullivan (1956). It may exist entirely as a cognitive enclave isolated from behavior, or it may erupt into the field of action, either as discrete compulsive acts or as an organized other life.

More commonly, the experience of shame is associated with avoidance and inhibition, both of action and commitment to action. Shame most frequently, therefore, remains largely encapsulated in the secret
life, far from the sphere of interpersonal intimacy. Occasionally, however, it may enter the sphere of action, either through acting out or by externalization of shame. Acting out of shame, in the form of compulsive outbursts of behavior directly expressing part or all of the patient's secret life, may occur when the anxiety attendant on inhibition of action is great. Even when acted out and conscious, the behavior is felt to be alien, that is, it continues to be isolated from the cognitive system of the patient and is not integrated through inference-making into the patient's comprehension of himself. This is accomplished by massive implosion of affects, with a resulting increase of turbulent and chaotic feelings after such compulsive acting out.

Externalization of shame may occur. Especially as experiences evoking shame are accentuated, and the feelings threaten to enter awareness, some patients involve themselves in behavior in the environment that justifies their inner sense of shame. Actually, their behavior and exposure to experiences of shame and humiliation serve to maintain dissociation of even more threatening aspects of self. The felt experience reported with such behavior is that of shame, humiliation, and degradation. I have found that externalization of shame in certain extremely obsessional patients accounts for a great deal of compulsive behavior that we designate as perverse. I have treated extremely obsessional patients whose compulsive homosexual, exhibitionistic, fetishistic, or transvestite activities were expressions of this mechanism. I view this mechanism as being analogous to counterphobic phenomena in the hysteric where anxiety dominates the picture and the patient defiantly flies into the face of what she fears. In behavior that we may call "counterobsessional," the patient, dominated by his sense of shame, is impelled to behavior evoking that very experience. Just as the anxious patient may develop counterphobic attitudes and behavior to deny and rationalize anxiety, the obsessional patient may develop counterobsessional attitudes and behavior to deny and rationalize shame.

The dependency problems typical of the obsessional neuroses also result in characteristic sexual difficulties. The obsessional's marked infantile dependency cravings are acted out in his sexual relations in a variety of ways that may best be understood if we examine further his early life experience. Historically, the role the obsessional has played in his family has been a paradoxical one, in which he has been infantilized in regard to interpersonal skills and instrumental competence
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within the home, while considerable demands have been made for him to achieve outside the home in such areas as school and intellectual achievement or sports and athletic achievement. His insignificance to family life, coupled with the low premium put on him as a person in relation to his own needs and development, leads him to seek to verify his significance by performances of ever-increasing perfection. However, within the family, his dependent role fosters his feelings of insignificance and incompetence, even in the face of successes in the larger world. This historical picture is a most frequent paradigm of the obsessional's role in intimate heterosexual relationships. He doubts his competence and withdraws from performance or competence in tasks related to the simple business of living with others, even as he develops high degrees of skill and competence in outside areas that do not involve his intimate relationships, such as business or intellectual pursuits.

A cultural example of an extreme of such situations has been drawn by Zborowski and Herzog (1952) in their description of the cultural attitudes and family structure of the middle European Jewish shtetl. Men and boys were free of the responsibilities for the tasks of daily life, even to the extent of earning a living, so that they might devote themselves to the study of the Bible and the Talmud. Their area of greatest significance was outside of the family, while the women managed the family life. It is to this dynamic constellation that I attribute the fact that the Talmudic scholar has become almost the extreme model of intellectualized obsessionalism, and the reason why the term "talmudic" is so readily applied to any rather obsessional, overintellectualized, scholarly pursuit.

This peculiar contrast in the experience of the obsessional reflects itself in several ways in the dynamics of his sexual conflicts and their resolution. In intimate relations, his tendency to feel incompetent and insignificant, and his dependence on others both for care and for verification of his significance, places him in a bind in which he feels insignificant if no sexual demands are made on him, but anxious, inadequate, and resentful if they are made. His fear of being exploited, should he expose his vulnerability and need, leads him to maintain emotional distance from his sexual partner, and not infrequently to cloak his affectional needs as simply erotic demands. His dependent orientation in intimate situations is further seen by his passive wishes and fantasies about sex. Since being loved means to him being cared
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for and served, his wishes are for activity and even aggressiveness on the part of the sexual partner. Fantasies of passive acquiescence to aggressively sexual women and fantasies concerning fellatio are common. His dependency, and the feelings of insignificance and of rage that constantly accompany it, add to the burden of shame and fears of exposure which make intimacy so difficult for him.

Also related to this dependency is the fact that the obsessional substitutes performance for expressiveness. Adequacy and competence of performance guarantee more safety than the uncertainty of spontaneous expression. Stereotyped performance can channel the response of the interpersonal environment and create relative safety from the possibility of evoking a feared response from the environment. It is also seen as the ultimate denial of dependency, ineptness, and insignificance. Because of this preoccupation with performance, and the ability to play to an audience for a planned effect, the obsessional is often able to perform competently as a lover, given the appropriate interpersonal climate. Where intimacy does not exist, where the partner's narcissistic preoccupations bar her attempts to explore and interpenetrate the other, where there is no curiosity on the part of his partner as to who he is and what he is like, where there is no capacity on the part of the partner to react to the impact he makes on her, the obsessional can usually function or perform fairly well. His performance may also be enhanced if the audience, that is his partner, accepts the limited conditions of the performance and does not demand that needs other than those he defines be met.

However, the high premium placed on his achievement and performance, arising from his dependency, makes him particularly vulnerable to anxiety about sexual performance. Sex is often an agonizing test of his prowess, robbing it of pleasure or play. Relying heavily on intellectualized and mechanical competence, prone to ritualized and stereotyped performances, he is constantly threatened by the expressive ability required in successful sexual activity. Anxiety about performance, when added to the already large burden of shame and fears of exposure, may trigger symptom formation, such as withdrawal from sex or impotence, and may add to the dynamics of such conditions as premature ejaculation or retarded ejaculation.

The obsessional's difficulties with sexuality are further compounded by the existence of what I call the "ambiguous referential systems" that are derived from the duplicity of his early experience and from the characteristic patterns of family structure and interaction. As we
have seen, in the obsessional's early life experience, he has been the object of overcontrol and overprotection, which has been equated with and rationalized as the loving warmth and support of which he has been deprived. His early autonomous moves have met with disapproval when they were made outside the narrow confines of his parents' expectations and needs. Experimental and exploratory activity have been stifled, spontaneity and responsivity restricted as undesirable and dangerous. His experience has served to define masculinity as weakness and impotence and femininity as aggressiveness and effectiveness. In the area of intimacy, noncommitment is seen as freedom, being loved is equated with being served, exposure is associated with vulnerability, passivity and inertia connected with power, and tenderness identified with control. It is as though the obsessional has a private lexicon, derived from his experience, which defines important concepts concerning interpersonal relations in terms that often contradict common usage and his own explicit definitions. The resulting clash between these implicit and privately held referents with more explicit and syntactically shared meanings may create uncertainty or even paralysis. Without clear and unambiguous referential premises, the interpersonal world becomes a morass of poorly grasped and inadequately understood occurrences. The obsessional patient, more than any other, often finds it embarrassingly difficult to understand the meaning even of relatively simple interpersonal events. Much of the obsessional's ambivalence, uncertainty, vagueness, obscurity, indecisiveness, and problems of commitment are based on the confusion of meaning that results from these ambiguous referential systems.

The typical gender and role confusions and reversals of the obsessional are more correctly assigned to these ambiguous referential systems than to factors of bisexuality or unconscious homosexuality, concepts that, unfortunately, have served to confuse some of our thinking about sexuality. The gender identifications of the obsessional are related to his wishes for the power, strength, activity, and effectiveness he associates with the woman, as well as to avoid the weakness, impotence, and exploitability that he associates with the man. In his role identifications, he similarly yearns for the passivity he connects with power and the service that he equates with love; he flees the control he identifies with tenderness, the vulnerability he associates with openness and commitment, and the exploitation he expects from active giving.

It has been noted that obsessional patients often show a markedly
diminished sexual interest. Apparently impressed by the clinical facts of this diminished interest and withdrawal from sex, and by the reduced passion and excitement in the sexual act, Rado (1959) suggested that obsessional have a congenital deficiency in the capacity for orgastic pleasure. My own clinical experience does not agree with this hypothesis. Diminished sexual interest in the obsessional seems related to several dynamic factors. Perhaps most important of these factors is that of depression. As I have indicated elsewhere (Barnett, 1968) I find that some degree of depression is almost a constant finding in the obsessional. I would say that I have never seen an obsessional patient in whom either overt or covert depression is not a prominent feature. This can be attributed to the prominent use of the mechanism of implosion of affects. Phenomenally, depression is the felt or apprehended experience involved in implosion. The more massive and inclusive the areas of interpersonal living involved in implosion, the more extensive the depression. Dynamically, conflicts between giving and withholding, anger and tenderness, power drives and dependency, and narcissism and love are central to the omnipresent depression of the obsessional. The characteristic withdrawal of interest from the environment in depression is responsible for much of the obsessional's diminished sexual interest. Therapeutic intervention and alleviation of the depression, which is constantly in the background, is usually accompanied by a marked upswing in sexual interest.

The obsessional's need for control and the pervasive effect of that need on his interpersonal relationships and on sexual behavior has often been noted. Salzman (1968) used this need for control as a central explanation for most obsessional behavior. In my opinion, this need for control, of his environment and of himself, is not a central phenomenon but rather derivative of the need to maintain innocence so central to obsessional dynamics. In the interpersonal situation, control functions to minimize the threats inherent in intimacy, essentially the dangers of self-exposure and exposure to shame and humiliation. Historically, its most common root lies in the identification with a controlling parent with whom the patient had a symbiotic relationship. The dependency and suppressed rage inherent in this type of relationship, in which needs for tenderness are equated with a control-submission hierarchy, become the paradigm for interpersonal intimacy. When the high cost, for even counterfeit tenderness, is
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submission, to be the one in control is to avoid the dependency and rage that accompany the submission. At the same time, being in control allows one to design the conditions of intimacy and avoid areas threatening to self-esteem. Control, from this perspective, may be seen as an attitudinal and behavioral analog to denial. It is basically organized around the obsession's extreme dependency problems and their denial, serving to maintain innocence and avoid the shame and humiliation that would be inevitable if these aspects of the self-system were comprehended.

All these factors, evolving from the characterological structure of the obsession, affect his sexual life. The need to maintain innocence, the inferential disturbances, the mechanism of implosion, the ambiguous referential systems, the nature and structure of his dependency needs, as well as the derivative issues of performance, control, his sense of shame, and the organization of a secret life—all contribute to the stylistic difficulties with sexuality that characterize obsession living. They are also responsible for the major symptomatic expressions of sexuality prominent in obsession living.

Let us now examine briefly some major symptomatic expressions of obsessionality and relate them to the dynamic factors of the personality.

Premature ejaculation is a common symptom of obsessionality. It tends to occur in rather severely obsessionally men who show particular rigidity and an almost martinet-like exterior, combined with severe underlying infantile dependent attitudes. They tend to be rather paranoid toward women, with fear, suspicion, and projection dominating their attitudes in heterosexual relationships. Still caught in an unresolved symbiotic relationship with a controlling parent, their excitement is overdetermined both by the appeal and by the threat of total absorption by the partner should their brittle shell crack. Sexual excitement is potentiated by this ambivalent anxiety and by the shame and fears of exposure connected with their dependency and rage. Ejaculation occurs as an almost undifferentiated physiological response to this summation of affective overload. The intensely ambivalent, dependent, and paranoid attitudes to women create severe tension and uncertainty that precipitate the premature ejaculation. Fromm (1955) contrasted the anxieties of men and women in regard to the sexual act, attributing the man's anxiety to his role of performer, and the woman's anxiety to her dependence on
the man’s performance. He considers a man’s confidence in his performance essential to adequate male sexual functioning and a woman’s ability to trust essential to adequate female sexual functioning. In cases of premature ejaculation, in my experience, these distinctions are far from clearcut. The man in such cases, deeply distrustful of women, labors under a constant apprehension of rejection and is unable to depend on the continuity and stability of the woman’s presence for the duration of the sexual act. He cannot bear, either, even the short time interval of exposure and vulnerability that normal orgasm requires, convinced as he is of his partner’s essential malevolence, and of his own worthlessness. The pressure and meaning of time and its condensation in the dynamics of premature ejaculation are related to this profound distrust and fear that pervades his relationship to women.

The infantile nature of the conflicts, and the diffuse nature of the excitement and discharge, causes some of these patients to equate the premature ejaculation with urination, adding to the burden of shame and humiliation. The implosion of affects and inferential defects that occur to prevent comprehension of these phenomena are augmented by the development of obsessional thoughts concerning control. These thoughts are, in my opinion, secondary to the dynamics that cause the symptom and serve mostly to reinforce innocence.

Retarded ejaculation, in which orgasm is delayed or cannot be achieved despite the presence of erectile potency, is a fairly common aspect of male obsessional sexuality. Its equivalent in the female obsessional patient is the presence of retarded orgasm despite the presence of sexual pleasure and excitability during coitus. This symptom, in its simplest and most benign form, is related to the detachment and restraint of passion, which results from the obsessional’s implosion of affects and represents the sexual analog to the overintellectualized and unemotional presentation of the obsessional patient in all of his interpersonal activities. In this form, it is stylistic rather than symptomatic, especially in the case of the male obsessional, who frequently views his capacity to delay orgasm with some pride as evidence of his competence and adequacy as a lover. In more extreme form, however, it is clearly seen as pathological and often is connected with considerable mental and even physical discomfort, especially in those cases where the patient is totally unable to reach orgasm.

Close investigation of the more severe symptomatic expressions of
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retarded ejaculation and retarded orgasm reveals an almost constantly occurring intrusion into the sexual act of obsessional ruminations triggered by the conflicts engendered by intimacy. In some cases, the patient rationalizes his use of these fantasies as deliberate attempts to increase his potency or his competence as a lover, without acknowledging the fears of failure that necessitate them.

The form that this symptom takes in the female obsessional, that of retarded orgasm, must be differentiated from other forms of frigidity. The contrast with the hysterical form of frigidity is especially apparent, as the latter is characterized by sexual anesthesia through part or all of the sexual act. Different also are the underlying causes of these seemingly similar phenomena, for, though hysterical frigidity arises from the fear of sex, retarded orgasm stems from the typical mechanisms of the obsessional disorder, and these women rarely suffer from anesthetic forms of frigidity. The obsessional woman most usually experiences sexual pleasure and excitement despite the delay or absence of climax. As with the male, this symptom may progress to a point where considerable discomfort is experienced during coitus in desperate and frantic efforts to achieve orgasm.

The symptom complex of retarded orgasm in both male and female obsessional patients is determined dynamically by several factors: (1) The detachment and loss of expressive affect resulting from the need to maintain innocence and the mechanism of affective implosion; (2) The shame and fears of exposure, especially of dependency and rage, implicit in the obsessional's interpersonal transactions; (3) The preoccupation with performance with its narcissistic and defensive implications; (4) The intrusion of obsessional ruminations into the sexual act.

On both clinical and dynamic grounds, I disagree with Ovesey and Meyers (1968), who link the symptom of retarded ejaculation to paranoid rather than obsessional difficulties and who explain the dynamics as a displacement into the sexual area of a nuclear paranoid conflict of hostile rivalry toward men. My own experience is that, in all its degrees, retarded orgasm is a relatively common obsessional symptom, which occurs in either sex and is present even when paranoid symptoms are absent. Furthermore, in a previous communication (Barnett, 1968), I pointed out that paranoid and depressive tendencies are frequent developments in the obsessional character and may be readily understood on the basis of the cognitive organization of these conditions.

Impotence, in which there is a failure of erection at some point in
the sexual act, is a common symptomatic manifestation of obsessional sexuality. It represents the extreme of effective withdrawal and diminution of excitement which so characterizes the stylistic approach of the obsessional to sex and intimacy. The individual dynamics vary considerably with the details of the early experiences of the patients, but certain generalizations may be outlined.

Impotence reflects the genuine underlying sense of inadequacy and incompetence in interpersonal relations, which I have described above as characterizing the obsessional's early family experience. At the same time, it is a disowned statement of his dependency needs in which he manifests his helplessness and wishes to be given to rather than to give, without the necessity for cognitive awareness. It is a defense against anticipated exploitation by the woman, and a hostile retaliation by withholding and frustrating her. The frequency with which it occurs in men whose relations with women are characterized by competitiveness suggests, additionally, that the symptom may express conflict related to dominance and submission as much as conflict about sex. Finally, the paralysis results from the ambiguous referential systems derived from his background, which create increasingly confusing binds in intimate relationships. The bind tightens as the obsessional finds that, though weakness may be a potent weapon by which the female opponent is defeated, his triumph is clouded by further lowered self-esteem.

The vicious cycle that often occurs with impotence is exacerbated by the obsessional's absorption with performance as well as by his fears of exposure and self-revelation. His needs for sex then become confused with his needs to prove himself by performing, and this becomes a typical obsessional system, divorced even further from any reasonable approximation of the excited, need-oriented, even playful orientation to sex which is ideal.

Compulsive genital activity includes a group of symptoms characterized by the eruption of repetitive, compulsive, and often stereotyped behavior into the field of sexual activity. Compulsive masturbation and compulsive promiscuity, either heterosexual or homosexual, all fall within this category. Symptomatically, they appear to be rather typical compulsive activities. The patient, often without much sexual interest or excitement, feels compelled to perform the sexual activity. There may or may not be an accompanying fantasy, and the act is followed by temporary relief of tension. There is a cyclic ten-
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dency with return of tension and repetition of the act. Unlike other compulsive acts, however, compulsive genital activity rarely occurs in well-compensated obsessional whose obsessional defenses appear to be working reasonably well. When they occur in the obsessional (and compulsive genital activity occurs also in covert and agitated depressions, schizophrenic reactions, and psychopathic conditions), they have a long history. Compulsive genitality usually signals that the obsessional dynamism is working particularly poorly or that it has never worked well, and that the patient is in considerable trouble. Paranoid or depressive decompensations are the most common root of the problem. Still other patients prove to be schizophrenics whose obsessional defenses prevent psychotic deterioration.

Dynamically, compulsive genitality is triggered by an intensification of anxiety which occurs in relationship to increasing interpersonal isolation. Despite the limited repertoire of interpersonal operations that are available to the obsessional, he is, nevertheless, able to function fairly adequately within the confines of his defenses. With the advent of severe anxiety and the failure of his obsessional defenses, even these limited avenues of interpersonal relations are closed to him, and he is threatened with total isolation. The intense anxiety attendant on isolation or its threat causes the eruption of the compulsive sexual activity in an attempt to resolve the isolation, either in fantasy or in desperate attempts at pseudointimacy.

In patients who are markedly dependent and infantile, and whose past experience has structured considerable resignation to isolation, this threat may be handled by compulsive masturbation and fantasy resolution. They are generally found to be covertly depressed, but the anger and helplessness are not openly felt but are entirely diverted into the behavioral symptom and its associated fantasies.

Those patients who resort to compulsive heterosexual promiscuity to meet the threat of isolation are usually those who are more defiant and less intimidated by authority. They are, at the same time, more prone to isolate their feelings of tenderness from their sexual needs and to manifest their dependency conflicts in open needs for approval from women, and in covert exploitation of them. More prominent in these patients is the grandiosity and perfectionistic performance orientation that results from their dependency conflicts and their denial.

An interesting group of homosexual patients who show a markedly obsessional character formation and compulsive promiscuity can be
mentioned here. Their homosexuality seems organized largely around severe obsessional role and gender confusion, and their compulsive promiscuity around essentially counterobsessional mechanisms, which are detonated by the anxiety of isolation. In other words, their promiscuous behavior is largely an externalization of shame in an attempt to deny and rationalize the shame. Despite the seeming severity of their symptomatology, I have found these patients more amenable to psychoanalytic treatment and resolution of their homosexual problems than other types of homosexuals.

In summary, then, we find that the phenomena of obsessional sexuality are varied and range in severity from the stylistic to the symptomatic. The common roots of these sexual difficulties lie in the cognitive disturbances characteristic of the obsessional way of life. At the core of these difficulties are the obsessional's need to maintain innocence, his inferential disturbances and the mechanism of implosion that maintains them, the ambiguous referential systems that define his roles and expectations, and the nature and structure of his dependency needs. Derived from central cognitive difficulties, the obsessional patient develops a pervasive sense of shame and a secret life of fantasy or action which strongly influence his sexual life. Counterobsessional phenomena, excessive performance orientation, and needs for control are derivative issues that complicate the dynamics of his sexuality and prevent the intimacy and spontaneity that would be ideal.

The obsessional way of life is a poignant mixture of isolation, shame, tortured ambivalence and indecision, impotent yearning, and frantic attempts at restitution and substitute gratification. At the same time, the obsessional is absorbed in his aggression, power needs, narcissism, omnipotence, and grandiosity. The sexual life of the obsessional patient is often the battleground on which much of this conflict is waged; it is often the area in which major battles may be won in the patient's efforts toward intimacy, spontaneity, and freedom from the rigid confines of his cognitive prison.
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REFERENCES


