

Sexual obsessions and OCD

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ABSTRACT *Sexual obsessions are common symptoms of obsessive-compulsive disorder (OCD). The literal content of these obsessions superficially resembles other types of iterative sexual ideation, as seen in the paraphilias, PTSD, and normal sexual fantasy. However, their form, function, and effect on behavior vary greatly. A failure to distinguish these different categories of sexual thought can lead to confusion and iatrogenic treatment. This paper will describe the content and form of sexual obsessions, clarify salient differences between sexual obsessions and other repetitive sexual thoughts, and finally discuss ways of treating sexual obsessions when they are symptomatic of OCD.*

Introduction

While many individuals who present for sex therapy worry about the adequacy of their sexual performance, another presenting group worry more about their sexual thoughts, fantasies and orientation. This latter group of people, who express concern about their sexual ideation, question the morality and significance of different sexual thoughts. They may complain that their thoughts seem repetitive, perverse, intrusive and immoral. When sexual ideation takes on these qualities, we refer to it as obsessive. People with sexual obsessions suffer from secondary disturbances in mood, impaired concentration, low self-esteem, and various inhibitions in sexual behavior. This paper will discuss the qualities of sexual obsessions, compare sexual obsessions with other repetitive sexual ideation, and lastly describe ways of treating sexual obsessions within a cognitive-behavioral model.

Sexual obsessions

Obsessions are repetitive, persistent, unwanted thoughts or images that cause personal distress and and/or interfere with functioning (APA, 1994). Obsessions are involuntary and unwelcome. They cannot be willed away. Efforts to suppress obsessions generally fail and paradoxically increase obsessive ideation (Wegner, 1994). This phenomenon is referred to as the thought suppression paradox. Typical obsessive themes center on religion, aggression, illness and sex, or a combination thereof. Obsessions tend to make the sacred profane. Whatever is most important

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obsessions can occur without any compulsions and then may be referred to as pure obsessions.

Repetitive sexual ideation is not unique to OCD; it also occurs in the paraphilias, post-traumatic stress disorder (PTSD), and in the fantasy life of the general population. The recurrent sexual thoughts, feelings and images in all of the above conditions are sometimes loosely referred to as 'sexual obsessions'. Yet their content, form and meaning will vary markedly between categories.

Sexual fantasy

Sexual obsessions in OCD are the antithesis of the usual sexual daydream or fantasy. Sexual fantasies generally are pleasant, harmless and relatively guilt-free. They may represent unfulfilled wishes or memories of past sexual experiences. Sexual fantasies are considered an indication of sexual desire (Kinsey *et al.*, 1948) and often enhance sexual arousal. They may include graphic details of a fantasized sexual script. In marked contrast to most sexual fantasies, the sexual ideation in OCD is extremely unpleasant and upsetting. The person with OCD never wants to act out the thought; instead he or she wants to stop thinking about it. Sexual obsessions in OCD are not part of one's sexual script and rarely produce sexual arousal. They often concern blasphemous thoughts (e.g. about the sex life of the Virgin Mary) or moral judgments (e.g. she's a slut or I'm a queer). They induce high levels of guilt and interfere with everyday functioning. Although some sexual fantasies also induce guilt and distress (Leitenberg & Henning, 1995), such fantasies are far less frequent, distressing and resistant to change than sexual obsessions in OCD.

Sexual ideation in PTSD

Sexual thoughts in PTSD are similar to those in OCD in that both are recurrent, intrusive, anxiety provoking and ego diminishing. PTSD of course represents the memory of an actual past event; obsessions in OCD represent fictitious, hypothetical events. Sexual ideation in PTSD is often graphic and detailed, whereas in OCD it tends to be vague and intellectual. However, both can inhibit sexual arousal and impair performance. When on occasion they do accompany or produce sexual arousal, the individual feels confused and extremely guilty. Both disorders lead to attempts at thought suppression and avoidance of cues that trigger the sexual thoughts. As these coping strategies fail, the afflicted individual may panic and fear losing one's mind. High levels of shame may preclude the use of one's natural social support network for OCD and PTSD.

In some instances, a history of childhood sexual abuse has preceded the onset of both OCD and PTSD (Freeman & Leonard, 2000). In these cases, the sexual abuse incident may be incorporated into the OCD symptomatology. This author treated a patient with a history of sexual abuse as a child whose primary OCD symptom as an adult was a fear that the devil would somehow or other enter him. The obsession had no explicit sexual content. Yet when asked to draw the devil, he sketched a picture of Lucifer with a transparent loincloth cloaking a long penis. The

TABLE I. Characteristics of iterative sexual ideation as a function of diagnosis

Characteristic	OCD	PTSD	Paraphilias
Repetitive	Yes	Yes	Yes
Personally distressing	Yes	Yes	Varies
Elicits sexual acts	No	No	Yes
Part of preferred sexual script	No	No	Yes
Based on past experience	No	Yes	Varies

sexual in their content only. In all other respects, they are better viewed as personally unacceptable cognitive intrusions.

Table I can be used to assist in arriving at a diagnosis. An accurate differential diagnosis requires assessment of the entire person in addition to a careful specification of the sexual concern. Although the comprehensive formulation of a diagnosis is beyond the scope of this paper, certain points deserve special attention in diagnosing disorders of sexual ideation. Sexual thoughts symptomatic of a particular disorder usually co-occur with other present or past symptoms of the same disorder. Thus, for example, someone with repetitive sexual thoughts symptomatic of OCD is likely to show other non-sexual symptoms of OCD as well, e.g. symmetry rituals or scrupulosity. The Y-BOCS Symptom Checklist (Goodman *et al.*, 1989) is a quick way of determining the presence of all major OCD symptoms. Its use enables the clinician to discover other targets for treatment as well as to gain confidence in diagnosing the sexual ideation. Using a similar logic, the clinician would want to look for other impulse control disorders when considering the diagnosis of paraphilia. When the differential diagnosis between OCD and paraphilia seems unclear, consultation should be sought, since their treatments are mutually exclusive and potentially harmful when misapplied.

Treatment

Accurate diagnosis, patient education, and open therapeutic communication provide the foundation for effective treatment. Exposure-Response Prevention (ERP) provides the critical, active ingredient.

All patients with sexual obsessions struggle to understand their occurrence and meaning. They typically attribute the obsession to being perverted, deviant, weak, immoral and crazy. Even mental health professionals who are unfamiliar with OCD have attributed the obsessions to vague concepts like latent homosexuality and potential paraphilia. Such misattributions further confuse and panic an already highly distressed individual. Thinking in terms of latent homosexuality can cause the therapist to make seemingly benign comments to the effect that being gay is a valid lifestyle choice. Instead of providing reassurance, such comments cause the patient to think that the professional believes they are homosexual.

reminded that many people sometimes experience embarrassing, intrusive sexual thoughts. Interpreting such thoughts in a catastrophic manner and then trying to suppress them increases their frequency. Instead of trying to suppress obsessions, patients should learn to adopt a dispassionate, scientific attitude towards their thoughts.

Learning to label the thought as an obsession can help patients with adequate insight attribute the obsession to their illness rather than to their true self. For patients with marginal insight, however, attempts at labeling will lead to ruminative debates about whether a particular thought is reality-based or obsessive. The therapist may be drawn into the process by providing endless ineffective reassurance. The net result is a type of dyadic OCD in which the patient obsesses, labels it as OCD, doubts the label, and then engages in reassurance seeking (the compulsion) with the therapist. The therapist provides the reassurance, temporarily allays the patient's anxiety, but inadvertently reinforces the obsessive-compulsive pattern. Two minutes later and the patient will ask the same question, 'Do I really have OCD or am I a pervert?'. Therapists need to be sparing in providing reassurance. A good rule of thumb is to reassure only once or twice and then redirect the question towards a focus on the form of the obsession. Patients can also be advised that the very existence of doubt about whether a thought is obsessive indicates that it is obsessive. For patients who then insist on knowing if the obsession is true or false, the therapist should reply that the goal of treatment is learning how to cope with obsessions—not proving them false.

Throughout treatment, open, direct and comfortable discussion about sex provides a general desensitizing influence. Patients with sexual obsessions are acutely embarrassed and ashamed by them. Being able to describe them in detail to a non-judgmental other person who understands their obsessive nature lowers the patient's anxiety and shame. Planned disclosures of the obsession to suitable people outside of therapy can further reduce the patient's shame (Newth & Rachman, 2001). Measured doses of humor also help. Because of their comfort and knowledge about sexuality, sex therapists who understand OCD are ideal treatment providers for these issues.

The most iatrogenic treatment occurs when the diagnosis of OCD is either not made or is confused with obsessive-compulsive personality disorder (OCPD). Patients then might be subjected to speculative inquiries into the root cause of their concerns. Although genetic factors appear important in the etiology of OCD (Alsobrook *et al.*, 1999), definitive psychosocial causes beyond general stress are not implicated in its development. Even in those rare cases where childhood sexual abuse appears to be incorporated into the OCD symptoms, it is unlikely that the abuse alone led to OCD. Treatments that emphasize interpreting the content of the obsession by exploring early developmental issues and family dynamics often prove harmful. The patient gets no relief, focuses on the literal content of the obsession, becomes increasingly confused, and then starts to obsess about past issues as well as about sex. Consensus guidelines on the treatment of OCD recommend only two empirically validated treatments: pharmacotherapy and cognitive-behavioral therapy (March *et al.*, 1997).

Therefore patients and therapists need to aim for partial improvement rather than total elimination of the obsessions. A goal of partial improvement is especially important for pure obsessions, since stray over-learned thoughts are likely to recur. By predicting their intermittent recurrence and normalizing their content, the patient is far less likely to panic and have a relapse.

The following case report illustrates the phenomenology of sexual obsessions, and some of the procedures and problems in treating them.

Case report

A 50-year-old married female was referred for treatment because she suffered from long-standing, multiple sexual obsessions, including obsessive preoccupation about being a lesbian. At the time of referral, she was in supportive psychotherapy and taking clomiprimine and sertraline for OCD and dysthymia. She worked at a part-time job and cared for her two children. Her marriage was stable but rather passionless. She described her husband as being tolerant and considerate but physically unattractive.

Background

The woman had grown up in an intact family. Her father was a perfectionist and demanding, with clear OCD symptoms. As a child she overheard her parents having intercourse on numerous occasions, because they lived in a one-bedroom apartment. The sound of her father breathing during sexual relations excited her. On occasion, she would then masturbate to orgasm. She felt extremely guilty about this, and she then began having intrusive obsessions about it. At 15 she developed an interest in boys. However, at a sweet sixteen party, she noticed that her lips quivered when she was looking at a certain girl. She panicked upon thinking that her quivering lips signified lesbian intent, which in turn meant that she must be a lesbian. Subsequently she developed intrusive thoughts and images of lesbian activity. During such thoughts, she noticed 'vaginal sensations', which in turn intensified her fears and caused her to avoid looking at attractive women. These sensations could only be described vaguely, but when asked she denied that they involved lubrication. She denied any history of sexual abuse or homosexual behavior. Nonetheless, she was terrified that she either was or might become a lesbian. She felt that homosexual behavior was acceptable and normal for others but completely unacceptable for herself. She saw it "like a sixth finger". A suggestion by an earlier therapist that she might want to explore issues around sexual orientation still disturbed her. She also had some doubts about being a woman; she worried that her clitoris stuck out too far and that a ridge on her head meant she was a man. These doubts, however, were fleeting and not seriously disturbing to her.

The woman got married for the first time in her early twenties. During this marriage she had frequent intrusive sexual obsessions about her father breathing and about homosexuality. The obsessions occurred most frequently during intercourse. Hence she avoided it whenever possible. Her infrequent sex life then increased her

ego-dystonic obsessions with no history of acting them out. The content of all the obsessions involved different types of proscribed sexual conduct or imagery. In her thinking, she blurred all distinctions between sexual ideation, intent and behavior. The fact that her concerns about homosexual intent were couched in inferential, impersonal language is typical of these cases. The phobic scanning for proprioceptive signs of sexual arousal, along with the monitoring of her thoughts for lesbian ideation when actually aroused, are also typical of OCD. These checking behaviors and ongoing attempts at thought suppression increased her preoccupation with homosexuality and interfered with everyday functioning as well as sexual enjoyment. In 34 years the obsessions had remitted only when she was involved in a satisfying sexual relationship with someone she found very attractive and masculine. That relationship briefly quelled her doubts about being a lesbian. Throughout her life the depressed mood was secondary to the OCD. The attendant shame and secrecy caused by the obsessions prevented corrective feedback and markedly damaged her self-esteem.

Her positive initial response to treatment seemed to result from being able to attribute the thoughts to OCD and from adopting an attitude of acceptance rather than resistance towards the obsessions. The subsequent relapse upon markedly reducing the anti-obsessional medication points to the obvious dangers inherent when patients unilaterally stop medication before solidifying treatment gains. Her extreme sensitivity to any signs of sexual arousal, i.e. 'vaginal sensations', suggests that more cognitive work was needed before proceeding with ERP.

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