



Sexual Obsessions in Obsessive Compulsive Disorder

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Overview of today's talk

- My background
- Overview of OCD
- Current treatments for OCD
- Sexual obsessions in OCD
- Sexual obsessions vs. ideation related to paraphilias/risk for sexual offending
- Case examples
- Q & A



What is OCD?

- OCD - Obsessive Compulsive Disorder
- OCD is an anxiety disorder; fear, anxiety, and worry are prominent features
- OCD is characterized by recurrent thoughts (obsessions) that the person finds upsetting and recurrent behaviors (compulsions/rituals) that the person does to try and decrease feelings of anxiety/discomfort

What is OCD?

○ **Criteria for obsessions (DSM-V)**

- Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety/distress.
- The individual attempts to ignore or suppress the thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

What is OCD?

○ **Criteria for compulsions (DSM-V)**

- Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

What is OCD?

○ **Diagnostic criteria**

- Presence of obsessions, compulsions, or both
- Symptoms are time consuming (e.g., take more than 1 hour per day), or cause clinically significant distress or functional impairment
- Symptoms are not attributable to another mental disorder, medical condition, or the effects of substance use
- *Specify if:*
 - With good or fair insight
 - With poor insight
 - With absent insight/delusional beliefs

How common is OCD?

- Prevalence of OCD is 2.5% (1 in 40)
- Among adults with OCD:
 - Usual age of onset is between ages 19-26 (slightly older for women)
 - Rates for men and women are equal
 - 65% had symptoms prior to age 25
 - 30% had symptoms starting in childhood
- Among children with OCD:
 - Usual age of onset is between ages 7-13
 - Boys outnumber girls 3:2 as boys tend to develop OCD younger than girls



Common obsessions

- Contamination obsessions
- Aggressive obsessions
- Sexual obsessions
- Religious/moral obsessions
- Somatic/body-focused obsessions
- Doubting obsessions
- Perfectionistic obsessions
- Superstitious obsessions
- Neutral obsessions



Common compulsions/rituals

- Decontamination compulsions
- Checking compulsions
- Perfectionistic compulsions
- Touching/movement compulsions
- Counting compulsions
- Mental compulsions

Rates of OCD Subtypes

Obsessions

- Contamination (50%)
- Doubting (42%)
- Somatic (33%)
- Aggressive (31%)
- Symmetry/precision (32%)
- Sexual (24%)*
- Religious (10%)

Compulsions

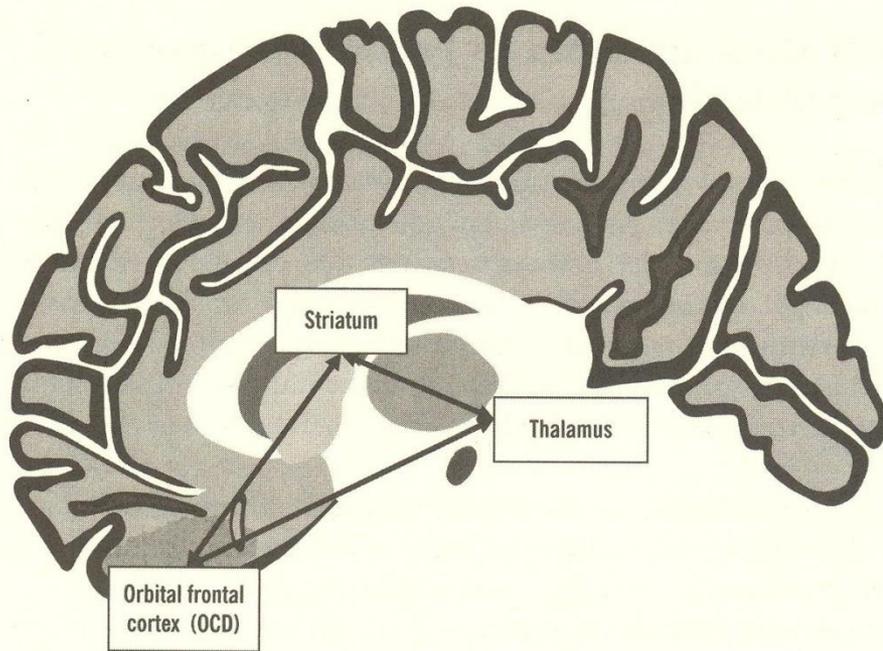
- Checking (61%)
- Washing/cleaning (50%)
- Need to ask/confess (34%)
- Symmetry/precision (28%)

Note: Based on rates of OCD symptoms in over 1000 patients seen at Butler Hospital at Brown University (Rasmussen & Eisen, 1998)

What causes OCD?

- OCD is considered a neurobehavioral disorder; the specific cause is unknown
- Evidence suggests that OCD is genetically transmitted, likely from multiple genes
- The neurotransmitter serotonin is seemingly related to OCD
 - Serotonin may not be sufficiently available in certain parts of the brain
- Several brain structures have also been found to be associated with OCD
 - Orbital frontal cortex, striatum, and the thalamus
 - These structures form a circuit in the brain and are interconnected; it is believed that this is where OCD symptoms develop in the brain

The brain and OCD



The cortical–thalamic–striatal–cortical circuit in OCD. Neuroimaging studies show abnormalities in these circuits when someone has active OCD and a return to normal when the person has had either cognitive-behavioral or drug treatment.

Orbital frontal cortex

- Threat detector (alarm)
- Sends messages to striatum that there is a problem to solve
- Triggered by many thoughts and external cues that don't bother others

Striatum

- Filter or brake pedal
- Determines what is a real threat/problem and what can be dismissed
- Does not function properly in OCD so most messages are sent to thalamus

Thalamus

- Relay station; sends signals to other parts of the brain to solve problems
- Communicates back to OFC that the problem has been solved
- In OCD this circuit does not close

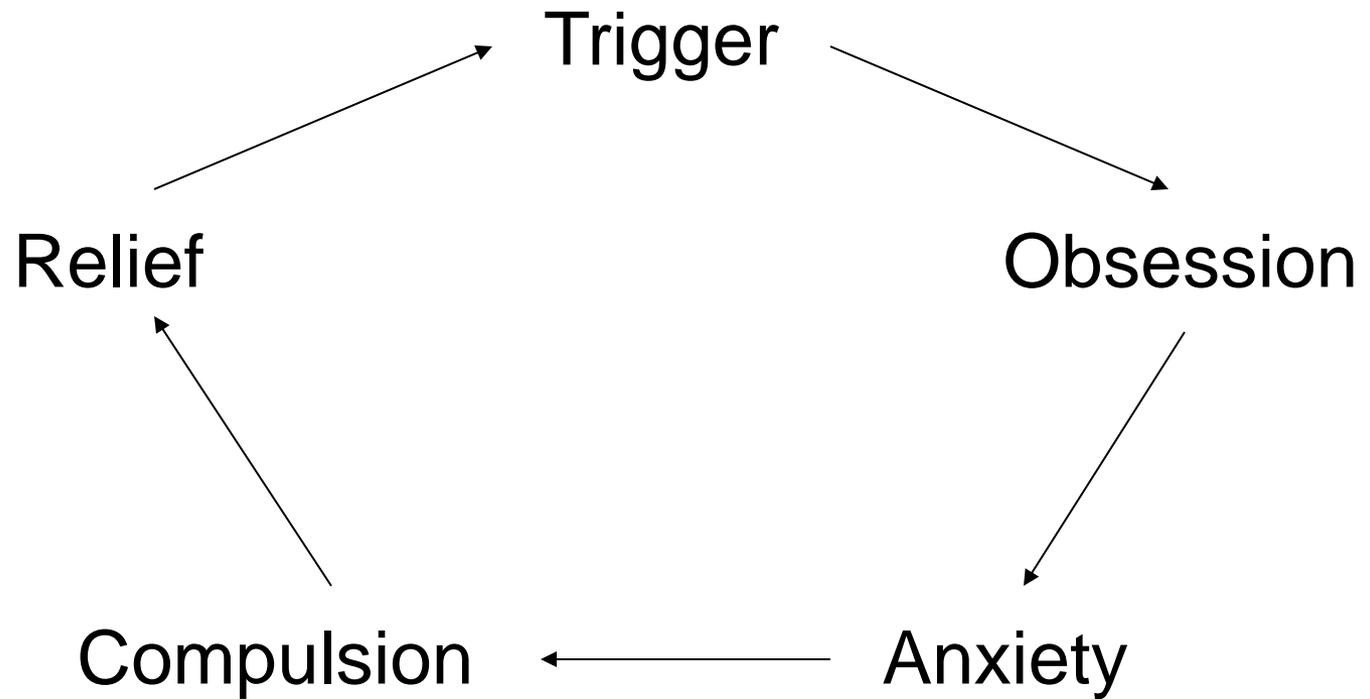
What causes OCD?

- Although biology likely determines who will develop OCD, learned behavior plays a critical role in maintaining OCD
- Once the “OCD cycle” gets started it is very difficult “break out” of because people learn that the only way to decrease anxiety is to perform their compulsions/rituals
- Learning how to stop, or “break out” of, the OCD cycle is essential for recovery and managing the disorder over time

The OCD Cycle

Example:	Contamination OCD - Fear of contracting HIV
Trigger	Red spot on a bathroom door handle
Obsession	"I'll get HIV if I touch that"
Emotion	Increased fear/anxiety
Compulsion	Avoid touching the handle or excessive hand washing if touch the handle
Emotion	Decreased fear/anxiety <u>for now</u>

The OCD Cycle



The OCD Trap

- The problem with compulsions/rituals is that they only help to decrease anxiety in the **short-term**; they do not fix the problem in the long-term
- The next time the person confronts an OCD trigger, his/her fear will increase again
- To feel comfortable, the person with OCD has to keep doing compulsions/rituals and the problem often gets worse over time
- The person may also require that other people participate in the compulsions/rituals; OCD can have a significant impact on families and relationships



How do you treat OCD?

- There is currently no “cure” for OCD, but good treatment can significantly decrease symptoms
- Two types of treatment have been extensively researched and found to be effective for OCD
 - Medication
 - Cognitive-behavioral therapy
- These interventions are considered to be the “gold standard” treatments for OCD
- OCD experts recommend trying these types of treatment first

Medication treatment - Adults

- Numerous clinical trials have found several serotonergic medications to be effective for treating OCD
 - Fluvoxamine (Luvox®), fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), and clomipramine (Anafranil®)
 - An adequate trial would be 10-12 weeks on a therapeutic dose before trying another medication
 - These medications are often augmented with another SSRI and/or an atypical antipsychotic medication when treatment response is poor

Medication treatment

○ Adults

- Meta-analysis of 32 clinical trials (n=3588) (Eddy et al., 2004) found that 63% of participants who completed medication treatment were improved at the end of treatment, as compared to 23% of those who received placebo

○ Children/adolescents

- Meta-analysis of 12 studies (n=1044) (Geller et al., 2003) found that medication was more effective than placebo
- Clomipramine was significantly more effective than the SSRIs (paroxetine, fluoxetine, fluvoxamine, sertraline) and the SSRIs were comparable to one another



Exposure and Response Prevention (ERP)

- The main cognitive-behavioral treatment that has been developed for OCD is called Exposure and Response Prevention (ERP)
- ERP was developed in the 1980's and has been extensively studied since that time
- At least 30 research studies have found ERP to be an effective treatment for OCD
- ERP is considered the first-line therapy for OCD
- It is important to refer clients to a mental health provider that has been trained and has experience using ERP to treat OCD

ERP – What is it?

- In the cycle of OCD, specific triggers lead to obsessive thoughts and feelings of anxiety/discomfort, and the person engages in avoidance or compulsions/ rituals to make the anxiety/discomfort decrease
- This cycle repeats itself over time as the compulsions only provide **temporary** relief and do not solve the problem long-term
- ERP teaches people how to break free of this cycle by changing their responses to OCD triggers and obsessive thoughts

Exposure

- **Exposure** involves directly confronting the triggers or obsessive thoughts that cause distress, instead of trying to avoid them or push them away
- Just as with any other fear, the more you confront the trigger for the fear, the less fearful you become over time
- For example, if you had a fear of heights, the more time you spent looking out windows in tall buildings, the less fearful of heights you would become over time
- The same principles apply with OCD, with one catch...

Response prevention

- In order for exposure to work in OCD, the person also has to stop engaging in the compulsions/rituals that decrease anxiety
- **Response prevention** involves purposefully not engaging in these compulsions and allowing oneself to experience the distress or anxiety until it goes down on its own
- Exposure does not work if the person is also engaging in compulsions/rituals, as these “undo” the exposure by making the person feel safe again
- Both exposure and response prevention are needed for the treatment to be effective

ERP – How does it work?

- ERP is based on the concept of **habituation**
- When we are repeatedly exposed to something over long periods of time, our nervous system “numbs out” to it
- Examples include adjusting to cold water a few minutes after diving into a swimming pool, or no longer noticing traffic noise after living on a busy street for several months
- The same principles apply to fear; when we are exposed to something that we fear for long periods of time, the nervous system adjusts to it and we no longer react as fearfully
- However, this only works if we don't try to escape or do something to make ourselves feel safer, which is why exposure only works if you also block compulsions/rituals



ERP – How does it work?

- Research suggests that ERP works by changing the way that the brain functions
- Imaging studies indicate that with ERP treatment alone (i.e., no medication treatment), changes occur in the brain that result in the brain working in a way that is more like people without OCD

ERP – What does it look like?

- ERP initially involves a comprehensive assessment of OCD symptoms (i.e., triggers, obsessions, compulsions/rituals, and avoidance behaviors)
- The therapist and client then create a list of the client's OCD triggers and rank these in order from those that cause the least anxiety to those that cause the most anxiety
- The therapist and client work on confronting triggers in session, starting with easier triggers, and work up the list until all triggers have been addressed
- The client also works on ERP during the week at home for the same triggers that were confronted in session with the therapist

ERP – What does it look like?

- ERP can involve both *in vivo* (or “in real life”) exposure and imaginal exposure and often the two are combined
- Imaginal exposure is helpful when triggers cannot be recreated for logistical reasons
- Imaginal exposure is also helpful for confronting obsessional thoughts that are not connected to specific behavioral rituals
- One way to do imaginal exposure is to record obsessional thoughts and fears in detail on a tape and listen to the tape repeatedly for long periods of time (until the client is bored vs. anxious)
- Some people may find it easier to start with imaginal exposure and work up to *in vivo* exposure



ERP – What does it look like?

- ERP is a short-term, focused treatment
- A typical initial course of treatment would be 15-20 sessions; some clients may need more sessions depending on the severity of their symptoms
- In moderate to severe cases, clients may need to start medication first in order to get some symptom relief before they are able to tolerate ERP
- Many people with OCD find that medication alone is not sufficient to manage their symptoms and also need ERP treatment to help reduce relapse

ERP – Empirical data

- ERP has been extensively studied and is the first line psychotherapy for OCD
- Meta-analysis (Eddy et al., 2004) of 18 ERP conditions from 15 clinical trials found:
 - 68.8% of completers were improved (defined as between 30-50% improvement)
 - 38.2% of completers were recovered
- Limitations: 30% don't improve, 25% refuse treatment, and 20% drop out of treatment
- Clinical practice outcomes may actually be better since longer-term treatment is an option for initial non-responders

ERP vs. combination treatment

- ERP vs. ERP + Medication
 - Mixed findings from several studies – slight trend for combined therapy being more effective
 - Largest study to date (Foa et al., 2005) examined ERP, CMI (clomipramine), and ERP + CMI
 - Results indicated that ERP and ERP + CMI were comparable, and both superior to CMI
 - This was particularly true with regard to relapse rates (12 weeks post-treatment): 11%, ERP; 14%, ERP + CMI; 45%, CMI
 - More research is needed to draw any definitive conclusions about combination therapy; the expert consensus panel (March, 1997) recommends combined therapy for severe OCD



Sexual obsessions

- Sexual obsessions in OCD can involve any unwanted, intrusive thoughts related to sex, including thoughts about
 - Molesting or having sex with children
 - Committing rape or other acts of sexual violence
 - Having sex with animals
 - Incest
 - Acting sexually toward others
 - Sex with religious figures or icons
 - Doubts about one's identified sexual orientation
 - Doubts about whether one acted in sexually inappropriate ways toward others

Sexual obsessions

○ Examples

- Mother who obsesses about whether she wants to touch her baby's genitals while giving him a bath or changing him
- Man who has obsessive thoughts about molesting children
- Young man who has thoughts about having sex with his younger sister
- Man who worries that he might be gay (with no previous attraction to men)
- Woman who obsesses about whether she touched people inappropriately while walking past them
- Man who has intrusive thoughts about sex with animals
- Young man who obsesses about looking at people's sexual body parts



Sexual obsessions

- People with OCD who experience sexual obsessions typically react to these thoughts with feelings of fear, anxiety, worry, disgust, shame, and/or guilt
- They find the thoughts distressing and are usually worried that the presence of these thoughts might mean that they are perverted or want to act on the thoughts
- People with sexual obsessions typically try to avoid the triggers for their obsessive thoughts (i.e., people, movies, books, articles, and settings that are related to their obsessions)
- This avoidance can lead to significant impairment in daily functioning

Sexual obsessions

- Behavioral compulsions/rituals associated with sexual obsessions can include
 - Confessing one's thoughts to others
 - Seeking reassurance from others
 - Looking away from others/distracting one's self
 - Praying and other religious practices
- Mental compulsions/rituals can include
 - Mentally retracing events
 - Analyzing and figuring out
 - Trying to force thoughts out of one's mind
 - Reassuring one's self
 - Scanning one's body for signs of arousal
 - Thinking a "good" thought to cancel out a "bad" thought

Sexual obsessions

- As with all other forms of OCD, avoidance and compulsions only lead to short-term decreases in anxiety and distress
- Treatment for sexual obsessions is the same as for other types of OCD
- ERP involves purposefully confronting the triggers for the obsessive thoughts, as well as the obsessive thoughts themselves (i.e., exposure), and blocking avoidance and compulsions (response prevention)
- Frequently, imaginal exposure is used more heavily when treating sexual obsessions, as some triggers/scenarios may not be possible or appropriate to recreate

Sexual obsessions

- Sexual obsessions in OCD are common
 - Prevalence rates range from 6-24% of people with OCD
- Rasmussen & Eisen (1998) found that in a sample of 1000 adults with OCD, 24% endorsed sexual obsessions
- Grant et al. (2006) found that in a sample of 293 adults with OCD (recruited from various treatment settings)
 - 13% reported current sexual obsessions
 - 25% reported a history of sexual obsessions
- Cruz et al. (2013) found that in a sample of 383 children/adolescents (ages 8-17) with OCD, 26% reported sexual obsessions

Sexual obsessions

- Content of sexual obsessions in children and teens (Cruz et al., 2013)
 - The most frequent sexual obsessions were forbidden or perverse sexual thoughts, images, or impulses ($n = 71$, 74.7%). Examples of these obsessions in our sample included worrying about being a pedophile or having thoughts about having sex with younger children, images of themselves having sex with family members, and images of having sex with dead people. Thoughts about aggressive sexual behavior toward others ($n = 39$, 41%), thoughts with content involving homosexuality ($n = 31$, 32.6%), and the category “other” ($n = 21$, 22.1%) were also frequent. Examples from the “other” category included worrying about making women pregnant after masturbating and worries that a boyfriend had been unfaithful.



Sexual obsessions

- Sexual obsessions are likely under-reported in OCD due to feelings of shame and worry
- Clinicians not familiar with OCD, or sexual obsessions in OCD, can make unnecessary and harmful reports to agencies (e.g., CPS) when these obsessions are disclosed
- This can lead to individuals with OCD dropping out of treatment or not seeking treatment
- Differentiating between sexual obsessions and sexual ideation related to paraphilias or risk for sexual offending is critical



Confusion about terms

- The terms “obsessions” and “compulsions” are often used in our culture in ways that are different from how they are defined clinically with regard to OCD
- This can lead to confusion when differentiating sexual obsessions in OCD from ideation related to paraphilias or risk factors for sexual offending
- Can’t assume that clients are using these terms in the same way that mental health professionals do
- It is important to operationally define terms when assessing sexual thoughts and behaviors to ensure proper diagnosis and treatment

Confusion about terms

- Obsessions – lay meanings
 - Often used to describe something that someone thinks about all the time or wants to do all the time (i.e., “obsessed” with pornography, sex, etc.)
 - Also used to denote inappropriate focus on a person or object, as in the case of stalking (i.e., he was “obsessed” with the woman and started stalking her)

Confusion about terms

- Compulsions – lay meanings
 - Often used to describe behaviors that people feel they can't stop themselves from doing (i.e., eating, spending money, stealing, exercising)
 - Also used to describe behaviors that people feel have an addictive quality (i.e., "sex addiction", "compulsive sexual behaviors")
 - Frequently describes problems with impulse control vs. ritualized behaviors seen in OCD

Differential diagnosis -

- Sexual obsessions (OCD)
 - Thoughts are intrusive and unwanted
 - Emotional reactions involve fear, guilt, and disgust
 - Physiological reactions involve typical anxiety/panic symptoms (i.e., increased heart rate, knot in the stomach, shallow breathing, crying)
 - Behaviors involve avoidance of triggers and efforts to make the thoughts go away



Differential diagnosis

- Ideation related to paraphilias or risk for sexual offending
 - Thoughts are more intentional and are likely experienced as pleasurable/enjoyable
 - Emotional reactions may include excitement and other positive mood states
 - Physiological reactions may involve states of arousal and/or relaxation
 - Behaviors involve approaching triggers and efforts to seek out experiences associated with ideation and desires

Differential diagnosis - cognition

Characteristics of sexual ideation as a function of diagnosis

Characteristic	OCD	Paraphilias
Repetitive	Yes	Yes
Personally distressing	Yes	Varies
Elicits sexual acts	No	Yes
Part of preferred sexual script/fantasy	No	Yes

Gordon (2002)

Differential diagnosis - arousal

- Arousal in the context of repetitive sexual ideation is generally more characteristic of paraphilias than OCD
- Arousal can occur in the context of sexual obsessions in OCD, but is not usually linked to the content of the ideation
- Instead, many people with sexual obsessions mentally scan their genitals for signs/sensations of arousal (a checking ritual) in an attempt to determine whether they are aroused
- The process of attending to sensations in one's genitals often leads to increased sensations/arousal
- Arousal related to sexual obsessions in OCD is generally a result of increased focus on sensations in the genitals and not a pleasurable reaction to the content of the thoughts

Differential diagnosis

- Three clinical presentations are important to differentiate when assessing a client with problems with sexual thoughts
 - Clear symptoms of OCD and no symptoms/ behaviors indicating risk for sexual offending
 - Presence of OCD symptoms and symptoms/ behaviors indicating a risk for sexual offending
 - Presence of symptoms/behaviors indicating a risk for sexual offending and no OCD symptoms
- Each will require a different treatment approach and likely referrals to different treatment providers



Treatment planning

- Careful assessment is needed to determine whether a client's recurrent sexual thoughts represent, OCD, a risk factor for sexual offending, or both
- Many mental health treatment providers are unaware that sexual obsessions are quite common in OCD and make the mistake of reporting clients who have no risk for offending
- Talking openly and non-judgmentally with clients about concerns when a diagnosis is unclear can help increase the likelihood that they will remain in treatment



Treatment planning

- Ensuring that clients get the appropriate treatment for their presenting concerns is critical, as the treatments for OCD and sex offending are quite different
- OCD treatment involves approaching triggers for intrusive sexual thoughts in order to reduce anxiety and decrease avoidance behaviors
- Sex offender treatment may involve decreasing exposure to cues for thoughts and urges that could increase risk for sexual offending
- Treating OCD or sex offending with the treatment for the other problem could have significant negative consequences

Resources for OCD - Local

- **OCD Support Group of Seattle**

- www.ocdseattle.org
- Monthly meetings in Seattle on the 3rd Saturday of the month from 10 AM – 1 PM at Swedish Medical Center; people with OCD and friends/family members are welcome to attend

- **The Anxiety Center at EBTCS**

- www.ebtseattle.com
- 206-374-0109

Resources for OCD - Books

○ **Self-help books for OCD**

- *Freedom from Obsessive Compulsive Disorder*
(Grayson, 2014)
- *Stop Obsessing*
(Foa & Wilson, 2001)
- *The Imp of the Mind* – “Bad thought” obsessions
(Baer, 2001)
- *The Doubting Disease* – Religious/moral obsessions
(Ciarrocchi, 1995)

Resources for OCD - Online

- **International Obsessive Compulsive Disorder Foundation (IOCDF)**
 - www.ocfoundation.org
- **Anxiety and Depression Association of America (ADAA)**
 - www.adaa.org