



SEXUAL OBSESSIONS – AND ITS VARIED FORMS

Psychiatry

**Dr Shubham
Verma***

Associate Professor, Department of Psychiatry, Muzaffarnagar Medical College and Hospital *Corresponding Author

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

KEYWORDS

Sexual Obsessions; Sexual Fantasies ; OCD; CBT

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 and cherished gets transformed into its opposite, producing ego-dystonic, blasphemous obsessions (Baer, 2001). For example, a new mother might obsess about sexually abusing her adored baby boy. She might worry about having such thoughts and about whether she could act them out. She would have no history of sexually abusing anyone and would profess genuine revulsion over the whole subject. Since sex is heavily laden with emotional, moral and religious significance, it can become a prime topic for obsessions.

The range of content in sexual obsessions is limited only by the imagination of the afflicted individual. Common themes deal with homosexuality, AIDs, infidelity, sexual perversions, incest and blasphemous thoughts combining religion and sex. The obsession can concern the self (e.g. 'I must be immoral to notice that woman's breasts'), a significant other (e.g. 'What if my wife is a whore?'), or a relationship (e.g. 'Is Diane the one to marry?'). These examples also illustrate that the content of sexual obsessions can be mundane and ordinary. Many people might have unfounded doubts about their spouse or experience guilt about certain sexual thoughts. For the obsessive, though, the high frequency, intrusiveness, and perceived perverseness of the thought distinguish it from similar thoughts of a person without OCD.

As they are occurring, sexual obsessions may seem real. A few seconds or minutes later, however, and the same obsession might seem ridiculous. Someone who steadfastly believes the false literal content of the obsession is described as having OCD with 'poor insight'. Such an individual would appear delusional or psychotic were it not for the delimited nature of the belief. Such patients generally have a poorer prognosis and may require low levels of anti-psychotic medication.

Most people with OCD have what might be termed variable insight. Often they know the obsession is false but occasionally it feels partly or fully valid. They are puzzled and frustrated over their inability to dismiss the obsession completely. Their insight is usually best when discussing the obsession with a therapist and worst when getting caught off guard by a sexual cue that elicits the obsession.

Obsessions are often posed as hypotheticals: What if I am a homosexual? What if I got AIDS from fingering a girl? By definition, the likelihood of an obsession coming true is remote. However, since they are formulated as hypotheticals, they can never be disproved. Objective feedback that seems to contradict the obsession (e.g. negative results from an AIDS test) can be discounted, because it lacks absolute certainty. The quest to prove the unprovable can lead to endless doubt, reassurance seeking, and the performance of magical compulsions. For someone with OCD, no level of statistical significance is ever low enough to dismiss the null hypothesis. 100% certainty is demanded.

Sexual obsessions can occur with or without compulsions. When present, the compulsion can be a behavioral act or a purely mental ritual. Examples of mental rituals include silent counting, repeating magical words, and arguing with oneself about the validity and significance of the intrusive thought. Such internal debates can last for hours and never reach a satisfactory resolution. Compulsions are performed to somehow nullify or undo the obsession. Frequently they temporarily reduce anxiety, but ultimately they strengthen the obsessive pattern. As noted, 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. The differential diagnosis between PTSD and OCD in such cases is based primarily on the presence or absence of compulsions, as well as on whether other OCD symptoms occur.

Sexual ideation in the paraphilias and cases of orientation confusion Repetitive sexual thoughts in the paraphilias are totally different from those in OCD and PTSD. In the latter disorders, the person finds the sexual ideation *ego-dystonic* and experiences revulsion at the thought of its enactment. The rape victim dreads the return of the rapist; the OCD sufferer dreads that the thought might magically come true. The paraphiliac experiences no such dread. For the paraphiliac, intense fantasies and urges to act out the thought produce sexual arousal and indeed often trigger deviant behavior. OCD sexual obsessions are rarely sexually arousing and never lead to their enactment. Paraphiliacs often rationalize their behavior by claiming that it is harmless and actually pleasurable for the victim. People with OCD never minimize or rationalize their sexual preoccupations. They see them as unequivocally immoral and pathological. The two most critical concepts in making a differential diagnosis are actual past behavior and intent. The paraphiliac has often performed the behavior, wants to repeat it, and feels sexual arousal. The obsessive has not performed it, wants to stop thinking about it, and feels disgust and fear over his inability to control his thoughts on the subject.

Similar criteria can distinguish genuine ambivalence about one's sexual orientation from obsessive thoughts about homosexuality. The genuinely ambivalent person will feel some positive attraction and arousal towards people of the same sex. This attraction may be apparent in daydreams, nocturnal dreams and masturbatory fantasy. This desire to engage in homosexual behavior is tempered by convict and reality-based fears over the consequences. The phenomenology of a straight person with homosexual obsessions is quite different. The person with OCD fears that his uncontrollable, 'disgusting' thoughts about homosexuality indicate that he is either gay or will become gay (*thought action fusion*). He wants to stop the thoughts and be reassured that he is not gay. He is extremely anxious, and he has no desire to engage in homosexual behavior.

Of course, people with OCD can also experience genuine ambivalence about their sexual orientation. For example, a compulsive hand washer might also feel uncertainty about her sexual orientation. However, such individuals do not show obsessive thought patterns about homosexuality; they might worry about it, and even agonize about it, but eventually come to terms with it after a period of experimentation. They do not have repetitive, intrusive thoughts about it. They obsess about other issues they find genuinely abhorrent or catastrophic.

Table I compares different categories of iterative sexual ideation. A perusal of it shows that sexual obsessions in OCD do not serve a sexual function. *They are 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

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

An accurate differential diagnosis requires assessment of the entire person in addition to a careful specification of the sexual concern. 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. 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.

What is needed instead of reassurance is an accurate diagnosis. The patient needs to understand that the sexual obsession is a product of OCD—not of his or her real inclination. Patients also need to understand that the obsessions are involuntary, harmless, and the opposite of their actual values and desires. They should be instructed that thought suppression tactics backfire and that obsessions will not cause them to become deviant or act out the thought. All these points will be eagerly accepted, then doubted, and ultimately forgotten. As such, they need to be reinforced periodically during the course of treatment. Bibliotherapy and OCD support groups can provide additional assistance in getting patients to understand the disorder and to accept its applicability to them as individuals.

OCD has been called '*the doubting disease*'. Patients will doubt themselves, their lovers and their treatment. They will assuredly doubt whether they in fact have OCD. They are good at finding loopholes, exceptions and little details that seemingly contradict the diagnosis. They are especially adept at finding evidence that supposedly supports the realistic nature of their fears. For example, a woman with obsessive fears of being a lesbian will note that she experiences 'vaginal sensations' when looking at other women. The fact that these same sensations occur unnoticed at other times gets overlooked. Or a man with obsessive fears about homosexuality panics if he catches himself noticing another man's crotch. This same individual fears that he would 'turn', i.e. become homosexual, if his wife touches his 'sex organ' and then touches his face. Such an event would signal that he could 'commit the act', i.e. engage in oral sex with a man. This type of magical thinking is common in OCD. To counter this type of thinking, patients need to be apprised initially that all cases of OCD vary in the particular literal content of the obsession. No two people will have identical obsessions just as no two people will have the very same dream.

Patients need to understand that the literal content of the obsession is irrelevant; it is "*full of sound and fury, signifying nothing*". The content will simply react something morally repugnant to that particular individual. The therapist needs to respect the patient's values and refrain from trying to convince the patient that certain sexual practices are legitimate and acceptable. From the patient's viewpoint, deviant sex is not and never will be normal or personally acceptable. Arguments over the morality and cultural relativity of sexuality will only detract from the therapist's legitimacy in the eyes of the patient and reinforce a negative emphasis on the content of the obsession.

Instead, the therapist will want to focus on the form of the obsession. The form refers to its frequency, duration, variability, intrusiveness and degree of situational specificity. Focusing on the form helps the patient to detach emotionally from the objectionable content. A

functional analysis mapping out antecedents and consequences lays the groundwork for later exposure and response prevention. Although one should not engage in debate about the acceptability of sexual behavior, the therapist should definitely emphasize the therapeutic benefit of accepting all sexual thoughts in a non-judgmental manner. The patient should be 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).

Exposure and response prevention (ERP) can be adapted to use in treating sexual obsessions. During ERP, the patient is repeatedly exposed to an upsetting obsession while prevented from engaging in any compulsions that lower anxiety. After peaking initially, the anxiety eventually subsides or extinguishes. The patient learns that anxiety decreases on its own; compulsions and mental effort become unnecessary for coping with the obsession. Prolonged, repeated exposures desensitize one to the obsession and break the link between the obsession and the compulsion. As that occurs, the frequency of the obsession decreases spontaneously. The goal of ERP, however, is not to eliminate the obsessive thought. The goal is to learn to tolerate and accept all thoughts with a modicum of distress. Their reduced frequency is a byproduct of their reduced noxiousness.

Although cognitive-behavioral approaches provide clinically significant improvement, complete symptom remission is the

exception (Eisen et al., 1999).

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.

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