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Differentiating Sexual Thoughts in Obsessive-Compulsive Disorder From Paraphilias and Nonparaphilic Sexual Disorders

Rachel A. Vella-Zarb, *Vancouver CBT Centre*
Jacqueline N. Cohen, *Nova Scotia Healthy Authority, Nova Scotia Hospital, and Dalhousie University*
Randi E. McCabe and Karen Rowa, *Anxiety Treatment and Research Centre, St. Joseph's Healthcare and McMaster University*

Recurrent sexual thoughts characterize several different psychological disorders, most notably obsessive-compulsive disorder (OCD), paraphilias, and nonparaphilic sexual disorders (NPSDs). Many clinicians are aware of the rule of thumb that sexual thoughts in OCD are personally distressing, whereas sexual thoughts in paraphilias and NPSDs are not distressing to the individual experiencing these thoughts, and they rely on this heuristic to inform diagnosis. This is problematic because distress alone is not a reliable diagnostic differentiator; as a result, misdiagnosis is common. Given the negative consequences of misdiagnosis, including worsening of symptoms, treatment dropout, and potential harm to individuals experiencing these thoughts or those who are targets of these thoughts, the purpose of this paper is to help clinicians identify and differentiate repetitive sexual obsessions in OCD from repetitive sexual thoughts in paraphilias and NPSDs. A clinical case example is provided along with pivotal areas of questioning to aid in differential diagnosis.

Darren is a 29-year-old single man who works full-time as an electrician. He was referred for an assessment of unwanted sexual thoughts about pubescent girls. He described experiencing frequent unwanted thoughts and urges about engaging in sexual acts with pubescent girls that were especially salient when he was in close contact with them. He was quite tearful throughout the assessment and described being distressed by these thoughts. He reported never having engaged in sexual behavior with an underage individual. He described wishing that these thoughts and urges would disappear, although he said that he sometimes found himself going places where he would be likely to encounter a young girl.

Recurrent sexual thoughts, images, or impulses are implicated in numerous disorders, most notably obsessive-compulsive disorder (OCD), paraphilias, and nonparaphilic sexual disorders (NPSDs). Many clinicians have heard the rule of thumb that sexual thoughts in OCD are unwanted and distressing, whereas sexual thoughts in paraphilias and NPSDs are wanted (or at least not distressing to the individual experiencing these thoughts), and they use this rule to differentiate between the different presenting problems. However, making a differential diagnosis among these disorders is not clear-cut in many clinical cases. Even with this rule of thumb in mind, many clinicians have difficulty identifying sexual obsessions as a feature of OCD and distinguishing sexual obsessions in OCD from sexual thoughts in other presenting problems. In a recent study by Glazier and colleagues (2013), 360 mental health professionals, the majority of whom were Ph.D.-level clinical psychologists, were randomly assigned to read one of five possible clinical vignettes depicting someone with OCD: Four of the vignettes provided a description of a male patient experiencing recurrent "taboo" obsessions (obsessions about homosexuality, sexual obsessions about children, religious obsessions, or aggressive obsessions) and one vignette involved a male patient with contamination obsessions. After reading their assigned vignette, participants were asked to select what they believed to be the principal diagnosis from a list of possible presenting problems and diagnoses. Participants were allowed to select more than one presenting problem and were asked to rank order their selection. If OCD was selected as any ranking by the participant, the vignette was considered correctly identified. Shockingly, findings of this study revealed that participants misidentified 38.9% of the vignettes as something other than OCD. The sexual obsessions vignettes resulted in the highest rates of misidentification (obsessions about homosexuality = 77.0% incorrect responses; sexual obsessions about children = 42.9% incorrect responses). In contrast, the contamination

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obsessions vignette was much more readily identified correctly as OCD (15.8% incorrect responses). These findings are troubling given the severe negative consequences of misdiagnosis, including improper treatment, poor outcomes, worsening of symptoms, and treatment dropout (Gordon, 2002; Hollander, 1998). A misdiagnosis of a paraphilic disorder instead of OCD could lead to increased feelings of shame and guilt on the part of the individual experiencing these thoughts as well as improper treatment that worsens or adds to symptoms, including unsuitable medication, involvement by child protection services, criminal investigation, or interpersonal and relationship problems. Conversely, it is possible that a misdiagnosis of OCD instead of a paraphilic disorder or NPSD could cause serious harm to the targets of the sexual thoughts, as empirically supported treatment for OCD with sexual obsessions involves exposure to unwanted sexual thoughts as well as exposure to stimuli or situations that trigger these thoughts (e.g., being alone with children). Further, misdiagnosis of OCD instead of a paraphilic disorder or NPSD may withhold appropriate treatment for the identified patient.

Given the severe negative consequences of misdiagnosis, and that misdiagnosis is common when recurrent sexual thoughts are part of the clinical picture, the purpose of this paper is to help clinicians identify and differentiate repetitive sexual obsessions in OCD from repetitive sexual thoughts in paraphilias and NPSDs. By identifying distinguishing characteristics of repetitive sexual thoughts in each of these diagnostic categories, more accurate diagnoses can be made and more appropriate interventions may be provided as a result. In this paper, a description of each of the aforementioned disorders will be provided, followed by key areas of questioning to help distinguish sexual thoughts seen in these disorders, as well as differences in treatment options based on diagnosis. Lastly, the case example introduced at the beginning of this article will be revisited with these key characteristics examined in order to illustrate how this additional information can help with differential diagnosis and subsequent treatment planning.

Diagnoses

OCD

OCD is characterized by the presence of obsessions (i.e., recurrent and unwanted intrusive thoughts, images, or urges) and/or compulsions (i.e., behaviors the individual feels compelled to perform in order to reduce distress; American Psychiatric Association [APA], 2013). Symptoms in OCD typically fall into one of several broad domains: symmetry/ordering, doubt/checking, contamination/cleaning, and "taboo" thoughts, which include aggressive, religious, or sexual obsessions. It is common for individuals with OCD to have obsessions and compulsions from more than one domain (Antony, Downie, & Swinson, 1998). When sexual obsessions are present in OCD, individuals are extremely upset by these thoughts and place a great deal of importance and meaning on what these thoughts say about them as a person (Purdon & Clark, 1999). There is also a sense of repugnancy that is not found to the same extent with other obsessions in OCD (García-Soriano, Belloch, Morillo, & Clark, 2011). Until more recently, some researchers argued that OCD with taboo obsessions does not involve rituals (e.g., Baer, 1994). More recently, however, research has demonstrated that those with taboo obsessions do in fact engage in rituals accompanying compulsions, but that these rituals more commonly consist of mental rituals (e.g., repeating the word "pedophile" several times; Williams et al., 2011), reassurance seeking (Williams et al., 2011), and avoidance of people or objects associated with the obsession (e.g., avoiding children or places where children are likely to be present; McGuire et al., 2012). Although taboo thoughts are common, with prevalence rates of intrusive sexual thoughts ranging between 3.2% and 24.9% among individuals with OCD (Brakoulias et al., 2013; Grant et al., 2006), these obsessions are often overlooked in educational materials for mental health clinicians and are more commonly misdiagnosed than other subtypes of OCD (Glazier et al., 2013). Examples of sexual obsessions include doubts about one's sexual orientation, thoughts about sexual acts with children, images of naked family members, questions about whether one has become aroused when seeing a child in a bathing suit, and thoughts about undressing or engaging in sexual acts in public. The results of some studies suggest that among individuals with OCD, those who have aggressive and socially unacceptable obsessions report the greatest symptom severity (e.g., Abramowitz et al., 2003).

Although OCD is equally prevalent among men and women, some researchers have found that when sexual obsessions are present, men are more commonly affected (e.g., Labad et al., 2008); however, other researchers have not found this to be the case (e.g., Grant et al., 2006). The average age of onset of OCD is approximately 19 years, but when sexual and other taboo obsessions are present, onset is earlier, typically shortly after puberty with a mean age of onset of 15 years (Grant et al., 2006). The international prevalence of OCD is 1.1% to 1.8% (Weissman, Bland, Canino, & Greenwald, 1994). Common comorbidities include depression, bipolar disorder, anxiety disorders, tic disorders, obsessive-compulsive personality disorder and, as mentioned previously, other types of obsessions and compulsions (APA, 2013). See Table 1.

Paraphilias and Paraphilic Disorders

Paraphilias involve intense and recurrent abnormal or atypical sexual interest (APA, 2013). They are characterized

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