Distinguishing between obsessive-compulsive disorder and paraphilias or nonparaphilic sexual disorders in a young patient with sexual thoughts

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ABSTRACT

Nonparaphilic Sexual Addictions (NPSAs), characterized by repetitive sexual thoughts and behaviors, have been suggested as falling within the obsessive-compulsive spectrum disorder. In comparison to individuals with NPSAs, those with Obsessive-Compulsive Disorder (OCD) reported significantly higher levels of fear and avoidance related to their sexual thoughts. Individuals with NPSAs reported elevated levels of sexual arousal associated with their thoughts and a greater degree of sexual pleasure derived from engaging in compulsive behaviors. In the context of this article, we will examine the case of a young patient who, while undergoing various therapeutic trials with antidepressants, has recently aroused suspicion of OCD due to the heightened intensity of his obsessive thoughts, particularly in the realm of sexuality. Additionally, we will highlight, following the specialized literature, some clinical aspects that may guide us in differentiating between these two pathologies.

Keywords: obsessive-compulsive disorder, paraphilias, nonparaphilic, sexual thoughts

INTRODUCTION

Recurrent sexual thoughts, whether in the form of persistent thoughts, fantasies, or urges, is a symptom that can be observed across a range of psychological conditions, including OCD, paraphilic disorders, and nonparaphilic sexual disorders. It is a common clinical practice to distinguish between these conditions by considering the individual’s emotional response to these thoughts; typically, the sexual ideation in OCD is intrusive and distressing, whereas in paraphilic and nonparaphilic sexual disorders, these thoughts may be experienced as pleasurable or at least not distressing. Despite this broad distinction, it is often quite complex to accurately differentiate among these disorders. In practice, the distinction is not always straightforward, as clinicians sometimes find it difficult to identify when sexual thoughts are symptomatic of OCD, or when they are related to different sexual concerns. This discussion endeavors to elucidate the nuances between OCD and Paraphilias or Nonparaphilic Sexual Disorders, offering clinical perspectives that may assist in distinguishing between them. The following narrative includes the examination of a case involving a 19-year-old individual grappling with sexual thoughts, with an initial differential diagnosis considering OCD.

Given the presence of repetitive sexual thoughts and compulsive behaviors in both OCD and NPSAs, some have inferred that NPSAs represent a subtype of OCD and consequently belong to a spectrum of obsessive-compulsive-related disorders [1].

Sexual obsessions in obsessive-compulsive disorder

OCD is characterized by the presence of persistent obsessions and compulsions. Obsessions are repetitive and unwanted cognitive intrusions thoughts, impulses, or images that are distress inducing. Compulsions are the repetitive behaviors or cognitive rituals performed in an attempt to mitigate the anxiety caused by the obsessions. Individuals with OCD often attempt to ignore or counteract these intrusive
thoughts with other thoughts or actions. The main intention behind these actions is to reduce the anxiety or prevent a feared event or situation, even though these behaviors are not realistically connected to the outcomes they are meant to avert. These obsessive and compulsive acts, consume significant time and lead to considerable interference with personal, social, occupational, and other important areas of functioning [2].

The estimated lifetime prevalence of OCD worldwide ranges between 1.1% and 1.8% [3]. On average, OCD symptoms tend to emerge around the age of 19. However, instances involving sexual or other taboo thoughts typically have an earlier onset, often emerging shortly after puberty, with the average onset age being around 15 years [4].

Among the various expressions of OCD, one notable subtype is characterized by intrusive sexual thoughts. These pervasive thoughts may include inappropriate or taboo subjects involving relatives, the deceased, objects, religious figures, or children, with a severity spectrum from mild to severe [3]. Similarly, approximately 24% of individuals with OCD report experiencing such intrusive sexual thoughts [5].

The experience of sexual obsessions within OCD is marked by significant psychological discomfort and a profound sense of concern about the implications these thoughts have for one's identity [6]. Such obsessions are often accompanied by a unique sense of revulsion, distinct in its intensity from other forms of OCD obsessions [7].

While early research suggested that taboo obsessions in OCD might not involve compulsive rituals, subsequent studies have clarified that such rituals do occur. These rituals can be covert, involving mental acts like repetitive word recitation or seeking reassurance, or overt, such as avoidance of specific people or settings that may trigger the obsessive thoughts [8-10].

Compulsions in the context of sexual OCD may include behaviors aimed at neutralizing the perceived threat, such as monitoring arousal responses or ensuring physical distance from potential triggers. Mental compulsions may also be present, like engaging in prayer or other cognitive strategies, in an attempt to counteract the intrusive thoughts. These efforts, whether manifest or concealed, are part of the broader compulsive response aimed at managing the distress associated with sexual obsessions in OCD [11].

Paraphilic disorders

Paraphilic interests are defined as persistent and intense atypical sexual interests, as outlined by the American Psychiatric Association (APA) [2]. The prevalence of paraphilic interests varies, with some studies suggesting a lifetime prevalence rate ranging from 2% to 12%, contingent upon the particular paraphilic focus [2]. There is a notable gender disparity in the manifestation of these interests, with males being more frequently diagnosed than females by a significant margin. The onset of these interests is commonly traced to adolescence, with a peak prevalence in the individual's 20s [12,13].

Paraphilias are characterized by repetitive sexually arousing fantasies, urges, or behaviors that involve distress to another individual, non-consenting others, or those unable to give legal consent [2]. It is important to clarify that a diagnosis of paraphilia can be made based on the presence of sexual arousal or interest alone, irrespective of whether the individual acts on these impulses. In other words, an individual doesn’t have to act upon their atypical sexual thoughts or urges to be diagnosed with paraphilia.

A paraphilic disorder is clinically recognized when such symptoms have been present for a minimum duration of six months and induce considerable personal distress to the individual (beyond societal disapproval) or involve activities that cause or have the potential to cause psychological or physical harm to others. The DSM-5 identifies several specific paraphilic disorders, each with distinct features, and it is not unusual for an individual to exhibit multiple paraphilic interests concurrently [2].

According to the DSM-5, the most commonly identified paraphilic disorders include voyeuristic disorder (secretly watching others engaged in private activities), exhibitionistic disorder (exposing one's genitals in public), frotteuristic disorder (touching or rubbing against nonconsenting others), sexual masochism disorder (undergoing humiliation, bondage, or suffering), sexual sadism disorder (inflicting humiliation, bondage, or suffering on another individual), pedophilic disorder (sexual focus on children), fetishistic disorder (using inanimate objects or having a specific focus on nongenital body parts), and transvestic disorder (sexually arousing cross-dressing) [2]. It's not uncommon for an individual to experience more than one type of paraphilia [14].

Non-Paraphilic Sexual Disorders (NPSD’s)

Similar to paraphilic disorders, the onset of NPSDs typically occurs during adolescence and peaks in the individual's 20s [12-14]. The estimated general prevalence of NPSDs ranges from 3% to 6%, although the actual figures could be higher due to the private nature of these behaviors [12,13].

NPSDs are also characterized by recurring sexually arousing thoughts, urges, or behaviors. However, unlike paraphilias, the sexual thoughts and behaviors associated with NPSDs are neither culturally unusual nor illegal [15]. Instead, they involve disinhibited or excessive versions of normative, culturally appropriate sexual behaviors that the individual feels compelled to perform, and these behaviors may or may not cause
distress [15]. Examples include compulsive masturbation, over-dependence on internet pornography, and promiscuity that results in significant distress or impairment [16,17].

NPSD, although not an official DSM diagnosis, has additionally been referred to as sexual addiction [18,19], sexual compulsion [20,21], paraphilia-related disorder [16], non-paraphilic sexual addiction [17], and hypersexual disorder [22].

If the behavior causes distress to the individual and/or disrupts normal functioning, a diagnosis of an impulse control disorder may be warranted. Unfortunately, there is limited research and clinical exploration into NPSDs, primarily because individuals with NPSDs often prefer not to disclose their behavior due to feelings of embarrassment or fear of judgment from others [17].

**Table 1.** Distinguishing between OCD, paraphilias, and NPSD [2,6,17,23,24]

<table>
<thead>
<tr>
<th></th>
<th>OCD</th>
<th>PARAPHILIAS</th>
<th>NPSD</th>
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</thead>
<tbody>
<tr>
<td><strong>Thoughts causing distress</strong></td>
<td>Individuals may experience immediate distress during the occurrence of the thoughts and continue to feel distress even after the thoughts have ceased.</td>
<td>There may be a tendency to experience excitement or arousal when sexual thoughts occur, with the intensity of distress varying after the thoughts have dissipated.</td>
<td></td>
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<tr>
<td><strong>Nature of the distress</strong></td>
<td>The distress is often related to the personal significance or perceived implications of the thoughts about one’s identity.</td>
<td>It is more commonly about the consequences for the individual experiencing these thoughts.</td>
<td></td>
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<tr>
<td><strong>Bothered by their thoughts:</strong></td>
<td>Yes</td>
<td>Some individuals may not anticipate harm to others from their thoughts and may not feel compelled to suppress them, while others may experience shame and actively try to control their thoughts.</td>
<td>May not find their thoughts or behaviors distressing and may not perceive them as excessive or problematic, despite concerns from those close to them. Others are concerned about the implications of these thoughts on themselves or the potential impact on others.</td>
</tr>
<tr>
<td><strong>Physiological response to thoughts</strong></td>
<td>In the context of OCD, individuals have shown significant fear and avoidance without evidence of sexual arousal.</td>
<td>In contrast, they showed little fear and displayed indications of sexual arousal.</td>
<td></td>
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<tr>
<td><strong>Thought content</strong></td>
<td>The content of thoughts may not differ significantly between the disorders. But the content can be much vaguer or questioning.</td>
<td>The content of thoughts may not differ significantly between the disorders. But the content of thoughts is more detailed and descriptive.</td>
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<tr>
<td><strong>Behaviors</strong></td>
<td>Compulsions, whether performed ritually or not, can be delayed if the individual chooses to or is unable to act on them immediately, even though there is a strong drive to complete the behavior. These actions are not enjoyable activities pursued for their inherent pleasure. Rather, they are neutral or often bothersome behaviors carried out to alleviate anxiety.</td>
<td>May approach these thoughts by observing related images, actively seeking stimuli for arousal, or replaying the thought with increasing detail. Masturbation to the thought might also occur. Actions may be executed in a ritualized manner, or not, and can be postponed if deemed necessary or desired, even though there is an intense desire to carry out the behavior.</td>
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Distinguishing between OCD, paraphilias, and NPSD

In Table 1, several aspects are summarized to aid in the differentiation of OCD, paraphilia, and NPSD. However, it is important to note that these are not differential diagnostic criteria but rather aspects derived from various sources to guide clinicians where applicable, enabling them to differentiate among the three pathologies.

CASE REPORT

We will present the case of P.A., a 19-year-old young man, who was brought by his family to the psychiatric hospital for the first time due to symptomatology characterized by concentration difficulties, depressive mood, low frustration tolerance, and irritability. This symptomatology is accompanied by
numerous sexual-themed thoughts that have been present for approximately a year. The patient underwent various therapeutic trials with antidepressants, and recently, there was suspicion of OCD due to the intensity that the sexual thoughts had reached.

There is no history of substance abuse, or anxiety disorder and no history of suicide attempts or psychiatric hospitalizations. He denied any prior history of compulsive sexual behavior.

Up to the present, the patient had not engaged in a relationship or visited prostitutes, but he used adult websites almost daily and masturbated. By the time he sought treatment, he started experiencing various problems at school, where he no longer wanted to engage, his grades began to decline, and he refused to attend school.

According to the parents’ statements, he began requesting information from his parents’ bank card, later informing them that he wanted to purchase various subscriptions on adult websites. The parents, who hold more conservative views, are concerned about the patient’s lack of inhibition in subscribing to adult websites.

During the hospitalization, the patient is calm and cooperative, presenting coherent speech. However, there is evidence of the presence of sexual-themed ideas lasting 2-4 hours per day, causing mild anxiety upon disappearance. This anxiety is heightened by the fear of being criticized by the parents or having close individuals discover these thoughts. Nevertheless, he acknowledges that the thoughts involving sexual themes are pleasing him. No compulsions are observed.

Under treatment with the antidepressant Venlafaxine 300 mg/day, the patient’s emotional progress has been favorable, showing improvement in mood, concentration, and reduced frustration tolerance. At the time of discharge, the patient receives a recommendation for cognitive-behavioral therapy, aiming to assist in managing sexual thoughts.

**DISCUSSION**

Studies suggest that the reported 24% of individuals with OCD experiencing these intrusive sexual thoughts may underestimate the actual prevalence due to factors such as lack of awareness, reluctance, shame, and fear of acknowledging this. Given the presence of repetitive sexual thoughts and compulsive behaviors in both OCD and NPSAs, some have inferred that NPSAs represent a subtype of OCD and consequently belong to a spectrum of obsessive-compulsive-related disorders [1].

However, they fundamentally differ in nature, as fantasies typically bring pleasure, while sexual obsessions involve unwanted repetitive thoughts that are intrusive. Individuals experiencing sexual obsessions continuously strive to eliminate these thoughts. Therefore, it’s important to note that sexual ideation or thoughts in OCD are highly distressing and unpleasant. Individuals with sexual OCD do not desire to act on these thoughts; instead, they strive to stop thinking about them. These thoughts bring about significant distress, and a heightened sense of guilt, and substantially disrupt everyday functioning.

The presented case of P.A., a 19-year-old with concentration difficulties, depressive mood, and sexual-themed thoughts, raises questions about whether the symptoms align more with NPSDs or OCD. The patient experiences sexual-themed thoughts lasting 2-4 hours per day, causing mild anxiety upon disappearance, but lacks the compulsions and time-consuming rituals characteristic of OCD. The thoughts involve culturally appropriate sexual behaviors such as excessive use of adult websites and masturbation. Despite the patient’s mild anxiety and fear of criticism, there is an absence of observed compulsions, indicating that the symptoms may align more closely with NPSDs. Additionally, disinhibited behavior is noted as the patient requests information from his parents’ bank card to purchase subscriptions on adult websites, contributing to the overall picture of NPSDs. While the sexual thoughts cause mild anxiety, the absence of significant distress or impairment, along with the improvement under treatment, suggests a nuanced clinical approach to address NPSDs rather than OCD in this particular case.

**CONCLUSION**

The presented findings highlight the intricate nature of differentiating between NPSDs and OCD, particularly when it comes to intrusive sexual thoughts. While studies suggest that the reported prevalence of such thoughts in OCD may be underestimated due to factors like awareness, reluctance, shame, and fear, it’s crucial to recognize the fundamental differences in these conditions. NPSAs, although sharing similarities with OCD in terms of repetitive thoughts and compulsive behaviors, are distinct in that the fantasies involved typically bring pleasure, whereas sexual obsessions in OCD are intrusive and unwanted, causing significant distress.

*Conflict of interest:* none declared  
*Financial support:* none declared
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