8 ICLICE 2017-147 Hossein Zakaryaee

Obsessive Thoughts Can Interfere In Sexual Dysfunction

Hossein Zakaryaee
Psychology Dept. Salman Farsi University, Iran
Zakarya832@gmail.com

ABSTRACT

Sometimes two or more disorders might co-occur or might have common symptoms. For instance, sexual thoughts can be associated with Obsessive-compulsive disorder. This study is a case report of exposure and ritual prevention and aversion therapy. The client was a 30-year-old client, white, male, who complained about erectile dysfunction and homosexual obsessions. He had a history of homosexuality and at the moment had changed his sexual orientation. He lived with his wife (female) and had difficulties with his sexual arouse. Obsessive-compulsive disorder symptoms involve unwanted thoughts about sexual relationship with other men and avoidance of situations where other men are present. It leads to depression and marital distress. The client received seven sessions of exposure and ritual prevention and aversion therapy. To investigate the effectiveness of treatment, Yale-Brown Obsessive Compulsive Scale, Hamilton Depression Scale (1960), Quality of Life Satisfaction Questionnaire, and self-monitoring were used. As a result, Cognitive behavior therapy was effective in reducing Obsessive-compulsive disorder and improving the mood, quality of life, and satisfaction of sexual intercourse with his wife.

Keywords: Cognitive behavior therapy, Sexual obsession, Obsessive-compulsive disorder, Erectile dysfunction, Homosexuality.

Introduction

Erectile Disorder (ED) is one of the most common disorders observed in 30% of 40-70 year-old males (De-Boer, Bost, Nijeholt, Moors, Verhill, 2005). Surprisingly, some researchers have stated that there is no the relationship between age and ED (Mirone et al, 2002; Ansong et al, 2000). WHO defines ED as the persistent or frequent inability in reaching or staying in sufficient erection for sexual satisfaction (Jurdin et al, 1999). Sexual functioning is one of the most important determinants of one’s life quality and impacts his/her mood, interpersonal relationships and personal satisfaction, family, work, health, general satisfaction and cheerfulness (De Busk et al., 2000, Kitai et al., 2002, Tan et al., 2007). Therefore, there is a strong relationship between men's concern regarding their partners' sexual satisfaction and their attempts for treating ED (Tan et al., 2007). The previous findings have showed that different factors might affect one’ s desire to seek professional help, factors such as socioeconomic and educational status, (Cor, L. 2002), tendency to marry (Sookdeb, S. 2007), severity of ED (Mirone, V.,at all 2002. Matic, H., McCabe, M. P. (2008), and psychological aspects of masculinity, i. e. being honorable, self-reliant, self-respectful (Sand et al., 2008).

It should be mentioned here that masculinity is defined differently in different cultures (Oliffe, 2005). However, some reasons prevent men from seeking professional help, reasons such as shamefulness (Fisher et al., 2005; Shabsigh et al., 2004; Perelman et al., 2005), age, in that younger men are shyer than elder men (Shabsigh et al., 2004), unwillingness to go to therapy, because the client might not feel at ease with the therapist (Perelman et al., 2005) which is further due to illegality of homosexuality in Iranian culture, and mistrust to treatment (Kitai et al., 2002;

Shabsigh et al., 2004; Fisher et al., 2005). Sometimes two or more disorders might co-occur or have common symptoms. For example, obsessional thought can be associated with ED.

Obsessive - compulsive disorder (OCD) is a kind of the anxiety disorders which is characterized by intrusive and frequent thoughts, ideas, images or impulses and leads to anxiety and mental resistance. Therefore, the individual is forced to show some observable or unobservable behavior based on inflexible rituals. Common themes related to OCD are contamination/cleaning, harm/checking, aggression, religion, sex, responsibility, symmetry/ordering, compiling and hoarding (Mckay et al., 2004; Foa et al., 2002; Abramowitz, Franklin, Schwartz, Furr, 2003; Mataix-cols, Rosario-campus, Leckham, 2005). According to the reports, OCD is prevalent among 1.6% to 2.3% of the population (Kessler et al., 2005; Ruscio, Stein, Chiu, Kessler, 2010). In clinical samples, obsessions have been reported more than compulsion and is more distressing than it (Maselli, Rector, Madifferential, 2003). Symptoms of OCD occur temporarily (Matrix- cols et al., 2002), and are cross- culturally stable (Matsunaga et al., 2008). They have distinct neural substrates (Mataix- cols et al., 2004) and are associated with patterns of comorbidity (Halser et al., 2005). However, a few number of studies in the area of sexual obsession (Gordon, 2002). Researchers have indicated that there are various types of sexual obsession, for example fears of molesting a child, engagement in inappropriate sexual activities, and intrusive sexual images (Monnica, Crozier, Powers, 2011).Compulsions which might occur along with sexual obsession include monitoring the level of arousal for determining sexual attraction, observing physical distance from others to avoid inappropriate touch or contact, or providing a reassurance that the individual is not sexually deviant (Monnica et al., 2011). Researches have reported that 9.9%- 11% of people with homosexual obsessions seek treatment during their life (Pinto et al., 2008).

Checking rituals is the most common compulsion (Samuels et al., 2006), and aggression and contamination are the most prevalent obsessions in OCD (Monnica et al., 2011). Studies have revealed that the etiological factors related to OCD are of various neural, genetic and neuropsychological type (Mataix- cols, Rosario- campos, Leckham, 2005). Cognitive behavior therapy (CBT), as a common treatment, has been indicated as effective in reducing OCD symptoms (Zucker, Craske, Blackmore, Nitz, 2006). In addition, to treat sexual obsessions, the principles of Ex/Rp can be used with long-term treatments (Grant et al, 2006). Ex/Rp is a kind of CBT which has been supported empirically in the treatment of sexual obsessions (Franklin, Abramowitz, Kozak, Levitt, Foa, 2000).

Case presentation

To adhere to the principle of client confidentiality, the obtained demographic information was altered. J. B. was a 30-year-old male with a diploma. He was working at the university, married and had a child.

The Chief complaint

J.B. complained about unwanted and intrusive homosexual thoughts. In addition, homosexual images interfered during his sexual intercourse with his spouse (female). Moreover, he was depressed.

History

In the first interview session, J. B. stated that he had been homosexual before. Then, he decided to change his sexual orientation and he got married to his present female spouse. Over the three years of his partnership, he experienced unpleasant, unwanted and intrusive homosexual thoughts which interfered during sexual relationship with his spouse. He demanded for help to get rid of these unwanted thoughts. He had not referred to a therapist due to his fear of being

judged. His spouse was unaware of his problem and he was always has worried that his spouse might find out about his secret and his sexual imaginations and decide to leave him.

Assessment

Before any treatment, assessment tools were used to determine the severity and frequency of obsessive thoughts. We used YBOCS to assess the frequency of obsessive thoughts. YBOCS is a semi-structured interview administered by the clinician and is used to assess the presence and severity of both obsession and compulsion. Based on the results of the present study, the obtained score for obsessive thoughts was 22. Additionally, J. B. was asked to discuss the situation(s) which might lead to a high frequency of his obsessive thoughts. For him, workplace, due to the presence of young males, was mostly triggering. To determine the level of depression, Hamilton Depression Scale, which is designed to assess the current symptoms of depression, was used at the beginning of treatment (depression score: 20). Moreover, the client had no suicidal thoughts. The scale was found to be highly reliable and sensitive to changes in severity throughout the treatment. Quality of Life Satisfaction Questionnaire, which is a self-report measure and is designed to assess satisfaction across multiple domains of functioning. Based on our findings, his sexual drive, interest and/or performance was poor (total raw score: 40).

Case Conceptualization

Regarding cognitive behavioral approach, the symptoms observed with J. B. could well represent OCD. In fact, thoughts and sexual images experienced by J. B., just as those of a large number of OCD clients, were unwanted, intrusive, and recurring. More importantly, they had negatively influenced his personal, social, marital and occupational status. J. B. had tried to avoid such repetitive and intrusive thoughts through changing his workplace and avoiding the places where he was in contact with young males. Avoiding stimulating environments led to a reduction in the rate of J. B.'s obsessive thoughts, therefore, he used it as a strategy. However, this strategy did not help him in solving his problem. Although he could temporarily reduce anxiety through the use of avoidance strategy, he faced some other problems such as loss of favorable social and occupational opportunities. The conflict between his thoughts and his use of avoidance strategy caused a great tension in his life and he gradually felt depressed and frustrated.

The Treatment Effectiveness Assessment

CBT approach was used to design a general treatment protocol for the client. Accordingly, treating intrusive sexual thoughts was considered as the most important problem to be solved.

Sessions one and two

The "thought stopping" technique was used in first sessions because the therapist considered it as an effective technique regarding the client's mental conditions. J. B. was asked to take note of the frequency of his obsessive thoughts in order to determine the baseline frequency for these thoughts and his weekly improvement. Avoidance behaviors were also discussed in these sessions. In the next session, J. B. stated that he could efficiently stop his intrusive thoughts only in the clinic, and thus the technique couldn't be considered as effective for him. Therefore, aversion therapy and a pre-designed stimulus called "aversive stimulus" were agreed upon to be used immediately after the occurrence of obsessive thoughts.

Sessions 3 and 4: After 15 days, it was revealed that the frequency of obsessive thoughts had substantially decreased. In these sessions, the practical problems for overcoming the intrusive thoughts were also discussed.

Sessions 5 and 6: After assessing the baseline to generalize therapeutic results to other situations and to stabilize treatment, the therapist asked J. B. to prepare a list of triggering situations which he had been trying to avoid. He was further asked to be in places with the most probability of triggering.

Session 7: The beginning and progressive phases of treatment were evaluated and, based on the analyzed data, a reduction was observed in the occurrence rate of obsessive compulsive thought. After observing that J. B. felt satisfied with the resultant changes and the treatment outcome, the researcher reassessed his level of depression. The results obtained through self-monitoring and clinician-administered measures indicated substantial decreases in OCD and depression symptom. His score for the YBOCS had fallen from 22 to 7, and for the HAM-D from 20 to 6. This was an indicator of minimal symptoms. In addition, J. B. reported a significant increase in his sexual desire.

Complicating Factors

Some challenges were faced throughout the treatment process. First, the client had some difficulty with homework, especially in relation to the "thought stopping" technique. Therefore, this technique was replaced by the "aversion therapy" technique. Other problems included providing the client with a rationale for the use of CBT model and especially explaining the concept of "avoidance". His wife was unaware of his problem and thus J. B. could not receive her support. In addition, J. B. was worried about judgmental issue and his therapist`s approach to him because homosexuality is illegal in Iranian culture.

Follow-up sessions

After four sessions of follow-up, at the end of treatment, J. B. reported that he had no serious problem and has no sever OCD and depression symptoms. He had better sexual intercourse than before, i.e. at the beginning of treatment. His quality of life had improved, as indicated by an increase in the total raw score from 40 to 60 for the Q-LES-Q-SF Scale. The EX/RP and aversion therapy were clearly effective in decreasing OCD symptoms. Reduction in depressive symptoms could be attributed to improvement in OCD. Finally, he was recommended to call his therapist or to schedule a session in case of any probable difficulty.

Implications of the study

There is a great potential for misdiagnosis, due to the nature of sexual thoughts and clinician's special attention to the typical symptoms of OCD, and thus OCD needs to be correctly diagnosed and well understood. The co-occurrence of changing sexual-orientation, ED and other disorders makes diagnosis difficult.

Recommendations

The successful results of aversion therapy and EX/RP for the present case suggests that unwanted sexual obsessions are a kind of OCD. However, they are differently defined in different cultures and communities. Moreover, masculinity in terms of ability to have satisfactory sexual relationship has an important effect on both marital partners. Sexual obsessions in OCD may be considered as taboo. Therefore, it is necessary for the therapist to uncover these thoughts and discuss all the avoidances and neutralizations with the client. Thought stopping technique and its effectiveness can also vary from one client to the other. In conclusion, it should be mentioned that openness of clinicians can be considered as one of the most important factors in treating taboo thoughts.

References

Abramowitz, J. S., Franklin, M. e., Schwartz, S. A., & Furr, J. M. (2003). Symptom presentation and outcome of cognitive-behavioral therapy for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology, 71*, 1049-1057.

Ansong, K., Lewis, C., Jenkins, P., & Bell J. (2000). Epidemiology of erectile dysfunction: a community-based study in rural New York State. *Annals of Epidemiology, 10*(5), 293-296.

Cor, L. (2002). *The psychology of men's health*. Buckingham: Open University Press.

De-Boer, B. J., Bost, M.L., Nijehholt, A. A. B. L., Moors, J. P. C., & Verhrij, Th. J. M. (2005). The prevalence of bother, acceptance, and need for help in men with erectile dysfunction. *Journal of sexual medicine,*2(3),445-450.

De Busk, R., Droy, Y., Goldstein, I., Jackson, G., Kaull, S., Kimell, K. J. B., Kloner, R. A., Lakin, M., Meston, C. M., Mitellman, M., Muller, J. E., Padma-Nathan, H., Rosen, R. C., Stein, R. A., & Zusman, R. (2000). Manegment of sexual recommendations of the Princeton consensus panel. *The American Journal of Cardiology,*86, 175-181.

Fisher, W., Meryn, S., & Sand, M. (2005). Communication about erectile dysfunction among men with ED, partners of men with ED, and physicians: The strike Up a Conversation study (Part II). *Journal of Men's Health and Gender, 2*(3), 309.e301-309.e312.

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., & Hajcak G., & Salkovskis, P. M. (2002). The obsessive-compulsive inventory: Development and validation of a short version. *Psychological Assessment, 14*, 485-496.

Franklin, M. e., Abramowitz, J. S., Kozak, M. J., Levitt, J. T. & Foa, e. B. (2000). Effectiveness of exposure and ritual prevention for obsessive-compulsive disorder: Randomized compared with nonrandomized samples. *Journal of Consulting and Clinical Psychology, 68*, 594-602.Gordon, W. M. (2002). Sexual obsessions and OCD. *Sexual and Relationship Therapy, 17*, 343 -354.

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Charney, D. S. (1989). The Yale-Brown obsessive-compulsive scale I: Development, use, and reliability. *Archives of General Psychiatry, 46*, 1006-1011.

Grant, J. e., pinto, A., Gunnip, M., Mancebo, M. C., eisen, J. L., & Rasmussen, S. A. (2006). Sexual obsessions and clinical correlates in adults with obsessivecompulsive disorder. *Comprehensive Psychiatry,47*, 325-329.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology and Neurosurgical Psychiatry,23*, 56-62.

Kessler, R. C., Berglund, p., Demler, O., Jin, R., Merikangas, K. R., & Walters, e.e. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national Comorbidity Survey Replication. *Archives of General Psychiatry,* 62, 593-602.

Kitai, E., Vinker, S., Kijner, F., & Lustman, A. (2002). Erectile dysfunction - the effect of sending a questionnaire to patients on consultations with their family doctor. *Family Practice,* 19(3), 247-250.

Maselli M, Rector NA, Richter MA. (2003). Quality of life in OCD: differential impact of obsessions, compulsions, and depression comorbidity. *Can J Psychiatry,* 48:72–77

Mataix-Cols D, Wooderson S, Lawrence N, Brammer MJ, Speck ens A, Phillips ML. (2004) Distinct neural correlates of washing, check ing, and hoarding system dimensions in obsessive-compulsive disorder. *Arch Gen Psychiatry*, 61:564–576

Mataix-Cols D, Rosario-Campos MC, Leckhan JF. (2005) A multidimen sional model of obsessive-compulsive disorder. *Am J Psychiatry*, 162:228–238

Matic, H., McCabe, M. P. (2008). Duration of erectile dysfunction and its relationship to treatment seeking and satisfaction with treatment using PDE5 inhibitors. *International Journal of Urology, 15*(4), 346-349.

McKay, D., Abramowitz, J. S., Calamari, J. E., Kyrios, M., Radomsky, A. S., Sookman, D., Taylor, S., & Wilhelm, S. (2004). A critical evaluation of obsessive-compulsive disorder subtypes: Symptoms versus mechanisms. *Clinical Psychology Review, 24*, 283-313.

Mirone, V., Gentile, V., Zizzo, G., Terry, M., Longo, N., & Parazzini F. (2002). Did men with erectile dysfunction discuss their condition with partner and physicians? A survey of men attending a free call information service. *International Journal of Impotence Research, 14*, 256-258.

Monnica T. Williams, Marjorie Crozier and Mark Powers (2011). Treatment of Sexual-Orientation Obsessions in Obsessive-Compulsive Disorder Using Exposure and Ritual Prevention. *Clinical Case Studies* 10: 53

Oliffe, J.(2005). Constructions of masculinity following prostatectomy-induced impotence. *Social* Science *& Medicine*, 60, 2249-2259.

Perelman, M., Shabsigh, R., Seftel, A., Althof, S., & Lockhart, D. (2005). Attitudes of men with erectile dysfunction: a cross-national survey. *Journal of Sexual Medicine, 2*(3), 397-406.

pinto, A., Greenberg, B. D., Grados, M. A., Bienvenu, O. J., Samuels, J. F., Murphy, D. L., nestadt, G. (2008). Further development of YBOCS dimensions in the OCD collaborative genetics study: Symptoms vs. categories. *Psychiatry Research,* 160, 83-93.

Ruscio, A. M., Stein, D. J., Chiu, W. T., & Kessler, R.C. (2010). The epidemiology of obsessive-compulsive disorder in the national Comorbidity Survey Replication. *Molecular Psychiatry,*15, 53-63.

Samuels JF., Riddle M.A., Greenberg B.D., Fyer A.J., McCraken J.T., Rauch S.L., Murphy D.L., Grados M.A.,Pinto A., Knowles J.A., Piacentini J.,Cannisstro P.A.,Cullen B., Bienvenu O.J. III, Rasmussen S.A., Pauls D.L., Willour V.L., Shugart Y.Y., Liang K.Y., Hoehn-Saric R., Nestadt G.(2006). The OCD Collaborative Genetics Study: methods and sample description. *Am J Med Genet B Neuropsychiatry Genet* 141:201–207

Sand, M., Fisher, W., Rosen, R., Heiman, J., & Eardley I.(2008). Erectile dysfunction and constructs of masculinity and quality of life in the multinational Men's Attitudes to Life Events and Sexuality (MALES) Study. *Journal of Sexual Medicine,5*(3), 583-594.

Sookdeb, S. (2007). An investigation of factors that determine when men with erectile disorder present for treatment. *Nurse Researcher, 14*(4), 76-88.

Tan, H., Ng, C. J., Chen, K. K., Sugita, M., Marumo, K., Lee, S. W., Fisher, W., & Sand, M. (2007). Prevalence and correlates of erectile dysfunction (ED) and treatment seeking for ED in asian men: The asian men's attitudes to life events and sexuality (MALES) study. *Journal of Sexual Medicine, 4*(6), 1582-1592.

Zucker B.G., Craske M.G., Blackmore M.A., Nitz A. (2006). A cognitive behavioral workshop for subclinical obsessions and compulsions. *Behav Res Ther*, 44:289–304.