Sexuality and obsessive-compulsive disorder: the hidden affair

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Practice points

- High percentages of sexual dissatisfaction have been reported in both women and men with obsessive-compulsive disorder (OCD).
- The excessive need to control their thoughts, high disgust sensitivity or the concealing of obsessional beliefs may hamper the person's capacity for intimacy and interfere with sexual functioning.
- Sexual obsessions are a common clinical feature in OCD, but are often misdiagnosed in both children and adults.
- Compulsive sexual behavior, either sexual paraphilias or nonparaphilic sexual behavior, share some clinical features with OCD spectrum disorders.
- Pharmacological treatment of OCD (mainly serotonin reuptake inhibitors) is associated with sexual dysfunction itself.
- Sexual problems have a deep effect on patient quality of life. If the dysfunction is attributed to pharmacological treatment it can make the management of OCD difficult, as it is one of the worst tolerated side effects and may challenge patient compliance.

SUMMARY

Obsessive-compulsive disorder (OCD) is a chronic condition estimated to affect 1–3% of the population, with older adolescents particularly prone to developing the disorder. It is characterized by the presence of obsessions (repetitive thoughts, images or urges that may lead to distress or anxiety) and/or compulsions (repetitive behaviors or thoughts performed in response to obsessions or according to rigorous rules). It is considered one of the most disabling anxiety disorders, and many aspects of quality of life are negatively affected by the disease. One of the less studied areas within OCD functionality is sexual health and behavior. Sexual problems in people suffering from OCD are multifactorial and can be explored by different (but not necessarily excluding) points of view. This article reviews and discusses clinical and therapeutic implications of the following issues: sexual health in OCD, sexual obsessions, compulsive sexual behavior (paraphilic and nonparaphilic sexual phenomena) and sexual dysfunction associated with pharmacological treatment of OCD.

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Sexual health in obsessive-compulsive disorder

Sexuality is a relevant aspect of functionality that has received little attention in the case of obsessive-compulsive disorder (OCD) patients. It is a very complex phenomenon in which many factors may converge to disrupt sexual functioning. There are many aspects that contribute to sexual dysfunction, and it should not only be attributed to pharmacological treatment or to an effect of the disorder itself [1].

Several classical studies report high percentages of sexual dissatisfaction and sexual dysfunction in OCD (54–73%) [2–4]. Despite some methodological limitations (small sample sizes, absence of control groups, gender-specific studies and retrospective data collection) there is quiet consensus that women and men suffering from OCD are often sexually dissatisfied and avoidant in their sexual relationships. Difficulties in interpersonal relationships are often associated with OCD [5]. Although the specific ways in which these difficulties lead to sexual or sentimental dissatisfaction are unknown, there seem to be some common aspects especially affected. Significant marital problems and distress have been reported for OCD patients [6]. Many patients do not have a partner (47% according to Freund and Steketee) [3] or have not had sexual intercourse for years [7]. Besides social skill deficits, other reasons have been proposed to be involved in trouble establishing and maintaining relationships for OCD patients. For example, the excessive need to control their thoughts and to take control [8], high disgust sensitivity [9] or the concealing of obsessional beliefs that may hamper the person’s capacity for intimacy (either because they fear that revealing obsessions will increase the probability of their occurrence, or that it will lead to shame and embarrassment) [10]. Moreover, fears of contamination can jam sexual functioning [2]. In recent work by Abbey et al., research is addressed to three specific points of romantic functioning: intimacy, relationship satisfaction and self-disclosure [11]. They concluded that the severity of obsessions (measured by the Obsessive-Compulsive Inventory-Revised) [12] were related to negative associations in all forms of intimacy. They also found a relationship between the Obsessive-Compulsive Inventory-Revised washing scale and worry about becoming contaminated through intercourse and oral–genital sex. However, other studies did not find this relationship with OCD severity and clinical dimensions. Vulink et al. assessed subjective appreciation of sexuality and sexual functioning in 87 female OCD patients and 27 healthy subjects, controlling for the influence of medication and OCD subtypes [13]. Compared with controls, patients more frequently reported low or absent sexual desire (62 vs 26%), moderate to severe sexual disgust (26 vs 4%), decreased or no pleasure with sexual thoughts (40 vs 19%), absent or very low level of sexual arousal (29 vs 0%), difficulties in reaching orgasm (33 vs 7%), dissatisfying orgasm (20 vs 4%), little or absent vaginal lubrication (25 vs 4%) and lack of pleasure in sexual activities (10 vs 0%). Although patients with OCD reported fear of sexual intercourse more frequently and hardly enjoyed it, they had similar frequencies of sexual intercourse to normal controls. Moreover, no significant differences were found for the role of medication, the severity of OCD or the different symptom subtypes (the dysfunction was not limited to patients with contamination obsessions).

Another interesting point to discuss is the onset of sexual dysfunction within the course of the disorder. Although patients explain sexual problems in the medical consultation after initiation of pharmacological treatment, some authors have reported high rates of sexual dysfunction prior to the appearance of OCD (20% according to Freund and Steketee) [3]. Kendurkar and Kaur compared sexual dysfunction in drug-free outpatients suffering from three different mental disorders: OCD, major depressive disorder (MDD) and generalized anxiety disorder (GAD), as well as in controls [14]. They found levels of sexual dysfunction in 76% of MDD patients, 64% of GAD patients, 50% of OCD patients and 30% of healthy controls. Severity of illness did not correlate with the severity of sexual problems, and orgasmic dysfunction was the most frequently reported complaint in OCD (but comparable with that found in women with GAD and MDD). In another study comparing sexual problems in OCD and social anxiety disorder, patients with OCD also reported more difficulties in reaching orgasm and less frequent effective erections [15]. The authors ascribe these findings to the need of OCD individuals to keep their own thoughts under control [8], when orgasm requires the capability to abandon self-control.

Although there is consensus on the fact that a number of OCD patients suffer from sexual...
difficulties and dysfunction, the majority of studies on the topic have methodological flaws, such as the absence of a placebo group, a baseline assessment (prior to the onset of pharmacological treatment) or the failure to use validated rating scales to assess sexual functioning. These factors limit the evidence about the rates of dysfunction within the disorder.

**Sexual obsessions**

Sexual obsessions are a common clinical feature in OCD that has received little attention in research. Reasons such as embarrassment in discussing sexual content or because this kind of obsession is sometimes denied seem to hinder the assessment of this specific issue. Sexual obsessions include several types of unwanted, unacceptable cognitive intrusions with egodystonic sexual content that can range from thoughts about family or children, concerns about sexual orientation, thoughts of sex with animals or fears about engaging in sexually aggressive behavior. Sexually intrusive thoughts are also highly prevalent in the normal population (93% according to Julien et al.) [16]. For some authors, clinical obsessions have their origin in these normal unwanted thoughts [17,18]. What distinguishes the unwanted cognitive intrusion of the nonclinical person from the clinical obsession of OCD is the meaning or appraisal associated with the intrusion. The thought–action fusion is a cognitive bias that can maximize the significance of an intrusion, involving an interpretation of the unwanted thought as morally or realistically equivalent to its behavioral manifestation [19]. Moreover, Wetterneck et al. recently reported that individuals endorsing negative beliefs about sexual desire experienced sexually intrusive thoughts more frequently (and they were perceived as more distressing) [20]. Negative, undesirable beliefs included the feeling of threat by sexual desire (lust and guilt), and according to the authors these could be mediated by cognitive factors such as an inflated sense of responsibility, the need to control thoughts and thought–action fusion.

Prevalence of sexual obsessions in OCD range from 20 to 30% according to different studies [21]. They have also been found in children (4% reported by Swedo et al.) [22], and some cases have been reported to be associated with previous sexual molestation [23]. Grant et al. found current sexual obsessions among 13.3% of patients, with 24.9% reporting lifetime symptoms [24]. They also found that patients with current sexual obsessions were more likely to report aggressive and religious obsessions (as reported by other authors [25,26]). Moreover, they also found that patients with sexual obsessions reported an earlier age of onset of OCD (15.1 ± 5.6 years) compared with subjects without them (19.0 ± 10.3 years). Previous literature, although limited, had examined clinical correlates of sexual obsessions. For example, they were thought to be more common in men with OCD [27] or in subjects with tic disorders [28]. They were also associated with poorer treatment response and with poorer insight [29,30], as well as with impaired sexual satisfaction [3]. However, these associations have not been found in later studies. In the sample of 293 patients in Grant's study, subjects with and without sexual obsessions did not differ in terms of clinical severity, insight, gender, response rates (to cognitive behavioral therapy or to pharmacotherapy), or sexual functioning or satisfaction [24]. In addition to the reasons stated above (the patients’ reluctance to refer sexual content), the fact that some of the previous studies had grouped sexual obsessions with religious or aggressive obsessions may explain the discrepancies observed between studies.

Within sexual obsessions, sexual orientation concerns have received specific attention by some authors. They include fears of becoming homosexual, fears that others might think one is homosexual or recurrent doubts about whether one is homo- or hetero-sexual [3]. The assessment of this issue is especially complex because this symptom can be misunderstood by clinicians and by patients as a sexual identity conflict, leading to potential flaws in treatment. Unwanted homosexual thoughts are also present in the general population [32] but OCD patients, once more, need to control these intrusive thoughts (as they are perceived as highly meaningful) and feel greater distress about them. Williams and Farris assessed clinical and sociodemographic correlates of individuals with specific sexual orientation obsessions in a sample of 409 OCD patients [33]. They found that 11.9% of patients endorsed lifetime symptoms, and were twice as likely to be male rather than female, with moderate OCD severity. Moreover, three Yale–Brown Obsessive-Compulsive Scale items (time, interference and distress) were found to be significantly and positively...
correlated with sexual orientation obsessions. These findings suggest that these patients may feel increased distress and be more impaired.

**Compulsive sexual behavior: paraphilic & nonparaphilic sexual addictions**

Excessive nonparaphilic (and paraphilic) sexual behavior has been related to the OCD spectrum in the last two decades. Excessive sexual behavior has received several names (hyperphilia, satyriasis, sexual addiction, sexual impulsivity and hyperactive sexual desire disorder) [34,35], with Coleman et al. the first to propose the term ‘compulsive sexual behavior’ to explain this phenomenonology [36]. Its main features are repetitive thoughts and ruminations associated with anticipatory anxiety or tension that are followed by ‘sexual compulsions’, initially resisted but later conducted to reduce anxiety or distress (similar to the relief perceived by OCD patients after concluding their compulsions). As opposed to paraphilias, excessive nonparaphilic behavior is considered an exaggerated repetitive behavior comprising culturally accepted normophilic sexual performances. The term impulsive-compulsive sexual behavior is used by Mick and Hollander to refer to all the representations of this behavior (that exclude paraphilias) [37] that Coleman classified previously in seven subtypes [36]: compulsive autoeroticism (repetitive masturbation that usually leads to genital injuries); compulsive use of the internet or telephone (for anonymous sexual outlets such as pornography); compulsive multiple love relationships (obsession and compulsion toward finding the intense feeling of a new relationship); compulsive sexuality in a relationship (unending needs for sex, expressions of love and attention that briefly relieve anxiety); compulsive use of erotica (obsessive and compulsive need to seek sexual stimulation through erotica, associated hoarding and hiding erotic materials); compulsive cruising and multiple partners (insatiable demand for multiple partners, considered as ‘things’ to be used, as part of a strategy for reducing anxiety and maintenance of self-esteem); and compulsive fixation on an unattainable partner (despite lack of reciprocal response).

On the other hand, paraphilias are characterized by deviant, socially unconventional sexual behavior (exhibitionism, voyeurism, and actions involving objects, children or other non-consenting persons) and are associated with high rates of sexual hyperactivity (72–80% according to Kafka and Hennen) [38]. The association between OCD and paraphilias come from few case reports, and to date it is not known whether the prevalence of these deviant sexual behaviors is higher or not in OCD. Some authors report cases of paraphilias and comorbid OCD improving with selective serotonin reuptake inhibitor (SSRI) treatment [39–41]. However, others report a higher amelioration of OCD symptoms with these medications compared with a mild or null effect on comorbid sexual behavior [42,43].

The OCD hypothesis has been proposed as a model to explain these deviant behaviors, but important inconsistencies arise to differentiate them. The most relevant is that pure obsessions in OCD are egodystonic, while repetitive sexual thoughts and actions in paraphilias (as well as compulsive sexual behavior) are usually egosyntonic. This means that sexual obsession in OCD is always unacceptable and never gives pleasure to the individual. However, feelings in paraphilias and compulsive sexual behavior are often positive and can act as triggers for engaging in sexual behavior, contrary to OCD patients who rarely engage in actions reflecting their obsessional thoughts (Table 1) [44].

Although some aspects such as the comorbidity of excessive sexual behavior with OCD and their similar response to SSRIs has been proposed by some authors to bring these disorders closer together [37], most authors support the conceptualization of excessive sexual behavior as an addictive behavior [37,44]. Similarities between these disorders include a craving state prior to behavioral performance, escalation of sexual activity, impaired control over behavioral engagement, withdrawal symptoms such as anxiety, guilt and rumination, related to a reduction of sexual activities, and continued behavioral engagement despite adverse consequences [45]. Moreover, comorbidities between excessive nonparaphilic sexual behavior and other addictions are significantly greater than with OCD; 64–71% in the case of addictions versus 15% with OCD [46,47].

Many medications, mainly high doses of SSRIs such as citalopram, fluoxetine and sertraline, have been reported to be effective in the treatment of paraphilic and nonparaphilic excessive sexual behavior [48–50]. However, other agents have also been cited in case reports as helpful in treating these disorders (atypical antipsychotics, lithium, methylphenidate, tricyclic
Sexual dysfunction associated with pharmacological treatment in OCD

Although there is a lack of studies assessing sexual dysfunction associated with pharmacological treatment in OCD, a lot of data describing the effects of antidepressants on sexual health are available. SSRIs and clomipramine are considered the most efficacious agents at relieving OCD symptoms. SSRIs have been reported to be particularly prone to causing sexual side effects, but data are highly variable, ranging from small percentages to more than 80% of cases [58]. According to the review by Soomro et al., the relative risk for sexual dysfunction for the different SSRIs (compared with placebo) range from 5.74 to 18.64 [59]. Sexual problems have also been found to occur in healthy volunteers after administration of SSRIs [60]. The majority of reports have been focused on SSRIs and it has been suggested that SSRIs lead to more sexual dysfunction than tricyclic antidepressants [61]. However, the reasons for the increased reporting of SSRI-related sexual effects (compared with other types of antidepressants) are not clear, and many reasons could be involved (e.g., the much wider use of the newer antidepressants, more recent systematic ways of obtaining data on sexual dysfunction and greater interest in the patient’s quality of life) [62].

Given the complex nature of the sexual dysfunction phenomena, the estimation of the incidence and prevalence of it varies greatly between studies. Some of the reasons suggested in the reviews by Balon [62] and Montgomery et al. [63] are the under-reporting of sexual problems by patients, the existence of methodological flaws due to the failure to use validated rating scales and the difficulties in establishing a normal population baseline. The incidence of global SSRI-associated sexual dysfunction would probably lie between 30 and 50%, but low percentages up to more than 80% have been reported. The differences for various SSRIs have also been studied, with great variations according to some authors [64–66].

SSRIs and clomipramine increase synaptic availability of serotonin. Stimulation of postsynaptic serotonin receptors are suspected to

| Table 1. Characteristics and examples of sexual obsessions, paraphilias and issues related to romantic love. |
|-------------------------------------------------|-----------------|-------------------------------------------------|
| **Sexual obsessions** | **Paraphilias** | **Romantic love** |
| **Characteristics** | **Paraphilias** | **Issues related to romantic love** |
| Cognitive, unwanted thoughts | Deviant, unconventional sexual behavior | Sentimental dissatisfaction due to several reasons (especially difficulties in interpersonal relationships) |
| Unacceptable, repetitive intrusions | Egosyntonic (usually perceived as exciting and positive) | Hampered sexuality |
| Unpleasant, do not represent fantasies or wishes | Associated with sexual hyperactivity (72–80%) | SSRIs may cause sexual dysfunction |
| Egodystonic | Poor response to SSRIs | – |
| High anxiety and negative ‘affect’ | – | – |
| Moderate response to SSRIs | – | – |
| **Examples** | **Paraphilias** | **Issues related to romantic love** |
| Fears of becoming homosexual | Exhibitionism | Sentimental dissatisfaction due to the need to take control, concealing of obsessions from the partner (shame and embarrassment) and social skill deficits |
| Fears of engaging in sexual activity with children or animals | Voyeurism | Hampered sexuality due to difficulties in reaching orgasm, low/absent sexual desire, less frequent effective erections, high sexual disgust sensitivity and worry of being contaminated by corporal secretions (in patients with contamination obsessions) |
| Fears of engaging in aggressive/harmful sexual behavior | Transvestism | – |
| Incestuous thoughts/images | Sexual actions involving children, nonconsenting persons and objects | – |

SSRI: Selective serotonin reuptake inhibitor.
be responsible for some of the adverse effects of these drugs, although various neurotransmitter systems seem to be involved [67]. All aspects of sexual function can be interfered with by SSRIs, mainly loss of libido and delayed orgasm (and also erectile dysfunction and delayed ejaculation) [58]. The assessment of sexual functioning in OCD patients is necessary for several reasons. First, there is evidence that OCD drug response is better at higher doses, compared with the standard doses used in depression [68]. Moreover, it has been estimated that 40–60% of patients do not respond completely [69] and maximum doses of SSRIs and augmentation strategies are commonly used, leading to higher rates of side effects. Augmentation strategies involve antipsychotic agents. Although there are differences between antipsychotic drugs, some of them have also been reported to induce sexual side effects [70]. In these cases, the pathogenesis of sexual dysfunction seems to be related to increased prolactin levels, although it may not be the only mechanism involved [71]. Sexual dysfunction induced by pharmacological treatment can lead to several problems in the management of psychiatric disorders. It is one of the worst-tolerated side effects, especially if the patient is a man [72]. In addition, older adolescents seem to be particularly prone to developing the disorder [73] and the onset of sexual problems can complicate normal initialization of sexual behavior or hamper the functioning of a previously sexually active adolescent. The results of previous studies in the Spanish population showed that 40% of men and 20% of women with sexual dysfunction had considered discontinuing treatment for this reason [70].

The assessment of sexual function should be performed using specific and validated questionnaires for obtaining quantified evaluation values. Examples of validated instruments include the Changes in Sexual Functioning Questionnaire [74], the Arizona Sexual Experience Scale [75,76], the Psychotropic-Related Sexual Dysfunction Questionnaire [76,77], the International Index of Erectile Function [78], the Derogatis Interview for Sexual Functioning [79] and the Female Sexual Function Index [80].

Listed in Box 1 are strategies recommended by specialized clinicians for the management of pharmacological-associated sexual dysfunction; for review see Balon [62] and Basson et al. [81].

**Conclusion & future perspective**

Sexuality in OCD is a field that has been scarcely studied despite the possibility of a significant relationship between some OCD features and sexual functioning. Some of the cognitive biases featured in OCD may affect sexual satisfaction and functioning. Furthermore, particular symptoms, such as contamination obsessions or high disgust sensitivity, may also impair sexual performance. Even fewer studies have been carried out on the impact of the presence of sexual obsessions.

The effect of drug treatment on the sexual functioning of OCD subjects may be another focus of concern. Patients with OCD are usually treated with SSRIs at higher doses and for longer periods than in other disorders and, therefore, it increases the likelihood of suffering from sexual dysfunction.

Sexuality is a domain to be taken into account in the assessment of OCD given that, on the one hand, sexual dysfunction due to the disorder may be frequent although not reported by the subject and, on the other hand, sexual dysfunction due to drugs may affect adherence to a treatment that is usually maintained for a long time.

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**Box 1. Management of pharmacological-associated sexual dysfunction.**

- Switch to a drug with lower incidence of sexual dysfunction: switching to antidepressants mirtazapine, bupropion or agomelatine may diminish drug-induced dysfunction (however, these drugs do not have an indication for obsessive-compulsive disorder); for antipsychotics, it is better to choose aripiprazole, quetiapine or olanzapine, rather than risperidone, amisulpride or paliperidone
- Wait for spontaneous remission of the dysfunction or for tolerance to develop
- Reduce doses of the antidepressant or antipsychotic (with continuous and rigorous assessment of clinical symptoms)
- Introduce drug holidays; the antidepressant can be discontinued for a brief period (e.g., 1–2 days), with sexual activity scheduled at the end of the period
- Add ‘antidotes’ or augmenting agents (i.e., tadalafil and sildenafil have been found to improve erectile function and overall sexual satisfaction in men with selective serotonin reuptake inhibitor-associated erectile dysfunction and may improve antidepressant-induced female orgasmic disorder) [82,83]
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Papers of special note have been highlighted as:
- of interest
- of considerable interest


### Relevant review of sexual side effects associated with selective serotonin reuptake inhibitor (SSRI) treatment.

Also offers management strategies and recommendations for SSRI-associated dysfunction.


### Focuses on the differential outcome of paraphilias, nonparaphilic sexual addictions and sexual obsessions after SSRI treatment.


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Review