**Desafios clínicos na Perturbação Obsessivo-Compulsiva com Obsessões Pedofílicas: Caso Clínico**

**Clinical Challenges in Pedophilia Themed Obsessive-Compulsive Disorder: Case Report**

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Resumo

Na perturbação obsessivo-compulsiva as obsessões pedofílicas - pensamentos intrusivos sobre ser sexualmente excitado, ou abusar sexualmente, de crianças - estão entre os mais angustiantes para os doentes e os mais incorretamente diagnosticados pelos profissionais de saúde.

O nosso objetivo é apresentar um caso clínico destacando o papel que o estigma tem no atraso do início do tratamento e os desafios clínicos que se verificam em relação ao diagnóstico e ao tratamento desta perturbação, de modo a colmatar a falta de literatura sobre o assunto.

O caso é relativo a um homem de 33 anos, com ideação suicida associada ao sofrimento insuportável causado pelas obsessões sexuais pedofílicas que tinha desde há uma década, sem nunca ter recorrido a um profissional de saúde. Esta situação teve muito impacto no seu funcionamento deixando-o maioritariamente isolado no seu quarto. Após o diagnóstico diferencial, implementou-se o projeto terapêutico combinando tratamento farmacológico e psicoterapia cognitivo-comportamental. Após 18 meses o doente apresentou uma melhoria significativa permitindo-o concorrer a um trabalho.

Palavras-Chave: Perturbação Obsessivo-compulsiva; Estigma; Pedofilia; Terapia Cognitivo Comportamental; Obsessões Sexuais

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Abstract

In obsessive-compulsive disorder, pedophilia-themed obsessions- distressing intrusive thoughts about being sexually attracted to, or sexually abusing, children- are the most distressing for the patients and misdiagnosed amongst health professionals. Our aim is to present a clinical case highlighting the role stigma plays in delaying treatment, the clinical challenges in the diagnosis and in the treatment of pedophilia-themed obsessive-compulsive disorder, to suppress the lack of literature on the subject.

 The case concerns a 33-year-old man with suicidal thoughts associated with the unbearable suffering caused by pedophilia themed obsessions he had been having over the previous decade, without ever asking for help. This situation was highly incapacitating leaving him mostly isolated in his bedroom. After the differential diagnosis was made, a treatment plan combining pharmacological and cognitive-behavior therapy was implemented. After 18 months he showed a degree of remission that made it possible for him to apply for a job.

Key words: obsessive-compulsive disorder; stigma; pedophilia; cognitive-behavioral therapy; sexual obsessions

**INTRODUCTION**

Patients with Obsessive-Compulsive Disorders (OCD) are generally reluctant to seek treatment (1) particularly if they suffer from obsessive contents involving sexually repugnant related themes such as pedophilic thoughts (2). Within sexual obsessions, pedophilia-themed obsessions (P-OCD), defined as excessive worries and distressing intrusive thoughts about being sexually attracted to, or sexually abusing children, are amongst the most distressing given the morally repulsive contents, shame and the fear of being misinterpreted (10;3) or imprisoned(3).

Although we have effective pharmacological and psychotherapeutic treatments to address OCD (8,10), P-OCD needs further clinical attention because current treatment manuals tend to be written in more general terms without addressing some specific and taboo examples of OCD (2), individuals with sexual obsessions may be considered more treatment-resistant (2) and particularly because P-OCD seem to be the most misunderstood and misdiagnosed symptom dimension in OCD amongst health professionals, which indicates that these patients are not properly attended in the mental health system(5,6).

**CLINICAL CASE**

The case concerns a 33-year-old male, unemployed for 3 years and with, living with his dad and brother and with a 12 year relationship with his girlfriend.

When he was 29 the patient was brought to the emergency room presenting with suicidal ideation: he couldn’t cope with the pedophilia themed obsessions that he had been having for the previous 10 years which had gotten worse in the previous 3 years, and progressively more so in the last couple of months.

He started by feeling that if he stared too long to his young nephews’ photos it would mean that he was a pedophile and that he could “ *lose control*” and act on it: he would immediately scan his body looking for bodily sensations or signs of sexual arousal, with a focus in the genital region, many times misinterpreting them, mistaking vegetative signs of anxiety (such as sweating).This took him to progressively avoid all triggering factors, such as direct contact with underage children, including his nephews, or through photos/tv programs with children - especially when nude or with few clothes.

He kept mentally replaying past interactions with children and doubting whether or not he had gotten aroused, or acted inappropriately, when touching them or seeing them.

He frequently felt the urge to seek reassurance, from his girlfriend, that he hadn’t written, in public places or on social media, that he was a pedophile. Lately he wouldn’t get out of the house alone, use the computer or the telephone, leaving him secluded in his bedroom. This avoidance kept him from finishing secondary school, finding a job or socializing, ultimately leading to hopelessness and suicidal thoughts.

After the differential diagnosis was made (see *Discussion*) a combination of Cognitive Behavioral Therapy and pharmacologic treatment was implemented, in accordance with the treatment guidelines for OCD with severe functional impairment (8).

The psychoeducation focused in the differentiation of pedophilia and pedophilic obsessions in OCD. The pharmacologic treatment (table 1) included a selective serotonin reuptake inhibitor, a tricyclic antidepressant and an atypical antipsychotic; a betablocker was also added (to reduce somatic manifestations of anxiety). The cognitive restructuring focused on the action-though fusion. In Exposure and Response Prevention, he was exposed to pictures of children, after hierarchization of the feared situations was stated (table 2), being prevented from avoiding the situation and realizing the compulsions. The patient also benefited from exposure immediately after masturbation: to confront the belief that the sensations the patient felt were not of arousal but signs of anxiety.

Besides presenting a strong embedded stigma toward psychiatric and psychologic treatment, and low insight for the disease, the patient adhered to the treatment. After 20 months of treatment, and several relapses, he was in remission: he completed a course and applied for a job. He plans to complete his secondary school degree soon and move in with his girlfriend.

**DISCUSSION**

The differential diagnosis should be primarily made with Pedophilia: the sexual arousal derived from recurrent fantasies, sexual urges or behaviors involving prepubescent children, that could, or not, involve sexual abuse of children (2).

There are clinical distinctions between these entities (11): the first is the ego-dystonic and marked suffering in patients with P-OCD, contrary to most pedophiles that present pleasure when imagining sexual acts with children. Besides, they enjoy being near children and experience sexual gratification when engaging in grooming activities (7). The opposite happens OCD patients given that they avoid all contact with children (2).

For some individuals this attraction for children is experienced with suffering and they decide not to act on it, motivated by moral values: in these cases it might be harder to differentiate(2) making it essential to investigate the degree of sexual arousal experienced, the sexual fantasies or if one masturbates themselves with mental images of children or child pornography(2). In this patient none of the criteria for pedophilia was present and the diagnosis was P-OCD.

This case brings into attention that sexual obsessions are likely underreported and under treated, being clear that the treatment was delayed for so many years, impairing the patients social, professional and personal functioning, due to the shame of having a psychiatric illness and fear of being received, by the health professional, with judgement or ridicule.

 Moreover, there is evidence that the risk of suicidal behaviors must be explored, particularly in those with symptoms of the sexual/religious dimension (15).

Likewise, individuals with obsessive thoughts from different symptoms dimensions might avoid disclosure of sexual obsessions even after disclosing other types of intrusive thoughts , because they are perceived as less acceptable: Cathey (2013) found that disclosure of an intrusive thought about a sexual theme is associated with more social rejection than disclosure of a contamination related intrusive thought.

 Thus, it is important that health providers normalize these types of concerns when interviewing OCD patients: Steinberg (2016) (14) , in a study about stigmatizing attitudes in clinicians, found that amongst professionals with cognitive-behavioral backgrounds, participants were more likely to socially reject or be concerned by individuals with obsessions related to contamination, harming, and sexual obsessions than those with scrupulous obsessions, and that they would be less likely to reveal sexual obsessions to others if they were experiencing them than the other three types of obsessions.

Even though there are scarce literature published on P-OCD it includes some anecdotal cases that report serious consequences for patients caused by uninformed mental health professionals(2), including a case in which the patient was wrongfully reported to the Child Protective Services; so, it is paramount to bring up awareness, investing in better training sessions and case supervision for psychiatry residents, specialists, nurses and other mental health staff, given that many clinicians are prone to misinterpret intrusive thoughts of a sexual or aggressive nature as a desire to commit such acts (5) .

TABLES

Table 1.

|  |  |  |
| --- | --- | --- |
| Class | Substance  | Dosis  |
| Selective Serotonin Reuptake Inhibitor  | Fluvoxamine  | Titrated until 350mg/day |
| Tricyclic Antidepressant  | Clomipramine  | Titrated until 225 mg/day  |
| Atypical Antipsychotic  | Risperidone  | Titrated until 6 mg/day |
| Betablocker  | Propranolol  | Titrated until 80mg/day  |
| Benzodiazepine  | Diazepam  | Titrated until 10mg/day  |

Pharmacologic treatment

Table 2. Hierarchization of the feared situations in a case of P-COD, prior Exposure and Response Prevention.

|  |  |
| --- | --- |
| Children looking more than 10 years  | Less anxiogenic More anxiogenic |
| Children between 5-10 years |
| Children looking less than 5 years |
| Children in swimsuits or undressed of all ages |
| Children looking less than 1 years |
| Patients underage cousins  |

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