Pedophilia-Themed Obsessive–Compulsive Disorder: Assessment, Differential Diagnosis, and Treatment with Exposure and Response Prevention

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Abstract Fears of sexually harming children are fairly common among clients suffering from obsessive–compulsive disorder (OCD), yet these symptoms are largely unrecognized and frequently misdiagnosed by mental health professionals. Specifically, clients with pedophilia-themed OCD (P-OCD) experience excessive worries and distressing intrusive thoughts about being sexually attracted to, and sexually violating, children. Expressing these concerns may provoke misjudgments from uninformed mental health professionals that a client is presenting instead with pedophilic disorder. This misdiagnosis and subsequent improper interventions can then contribute to increased fear, anxiety, and in many cases, depression, in affected clients. Therefore, it is imperative that mental health professionals first possess a good understanding of this common manifestation of OCD. As such, in this article, we described obsessions and compulsions typical of P-OCD, in order to inform the reader of the distinctive differences between P-OCD and pedophilic disorder. Information about how to assess for P-OCD symptoms is then provided, followed by suggestions on how to tailor aspects of exposure and response prevention to treat this specific form of OCD.

Keywords Obsessive–compulsive disorder · Pedophilia · Exposure and response prevention · DSM-5

Introduction

Obsessive–compulsive disorder (OCD) is a severe and disabling condition consisting of intrusive obsessions and repetitive compulsions. OCD tends to be particularly persistent, highly comorbid with other psychiatric disorders, associated with great functional impairment across multiple domains, and correlated with a significantly higher mortality rate from both natural and unnatural causes compared to the general population (Kessler, Berglund, & Demler, 2005; Meier et al., 2016). Pedophilia-themed obsessions may produce an even greater level of discomfort, anxiety, and shame for sufferers due to the distasteful and offensive nature of the obsessions. When the OCD is severe and persistent, clients are often unable to manage the disorder without specialized psychological intervention.

The most prevalent symptom dimensions in obsessive–compulsive disorder (OCD) are contamination concerns and compulsive cleaning, doubts about harm and compulsive checking, symmetry/ordering concerns, and unacceptable thoughts (Abramowitz et al., 2010; Abramowitz, Franklin, Schwartz, & Furr, 2003; American Psychiatric Association (APA), 2013; Leckman et al., 1997; Pinto et al., 2007). While much research has been undertaken to better understand contamination concerns and compulsive checking (e.g., Ball, Baer, & Otto, 1996), there has been less research attention on the unacceptable thoughts symptom dimension, which includes violent, religious, sexual, and otherwise taboo and morally repugnant obsessions (e.g., Pinto et al., 2007). This disparity is alarming, especially since unacceptable thoughts in general have been associated with poorer treatment outcomes, compared with other OCD symptom dimensions (Williams et al., 2011; Williams, Mugno, Franklin, & Faber, 2013).

The specific subset of sexual obsessions, found within the unacceptable thoughts symptom dimension, may involve fears about engaging in sexually aggressive behaviors, fears about
one’s sexual orientation/identity changing, or unwanted sexual thoughts and fears about children (i.e., pedophilia-themed OCD [P-OCD]; Pinto et al., 2007). Grant et al. (2006) found that approximately 24.9% of individuals with OCD had experienced sexual obsessions at some point during their lives. Additionally, Williams and Farris (2011) found that 16.8% of individuals seeking treatment for OCD reported current unwanted sexual obsessions. However, because the strongly stigmatized contents of such obsessions tend to increase symptom concealment due to shame or embarrassment (Cathey & Wetterneck, 2013; Newth & Rachman, 2001), actual prevalence rates are likely much higher than indicated. Despite the considerable prevalence of sexual obsessions among clients with OCD, many mental health professionals are still inadequately informed in terms of recognizing, assessing, and/or tailoring specifics of treatment to clients’ intrusive sexual thoughts (e.g., Glazier, Calixe, Rothschild, & Pinto, 2013).

The situation is especially dire in regard to the recognition, assessment, and treatment of symptoms of P-OCD, perhaps due to the lack of educational resources for clinicians. For example, existing clinician guides and self-help books for OCD tend to omit the topic of P-OCD, or even sexual obsessions in general (e.g., Foa & Kozak, 1997; Foa, Yadin, & Lichner, 2012; Schwartz, 1996). Additionally, the only cognitive behavior therapy (CBT)-oriented books that explicitly broached the topics of unwanted sexual, violent, or blasphemous obsessions unfortunately conceptualized such symptoms as constituting “pure-obsessional” OCD (see Clark, 2007; Purdon & Clark, 2005). This neglects the strong presence of mental compulsions in clients (described in detail further below) that often operate undetected in maintaining this form of OCD. The aforementioned books also frequently lumped together symptoms in the unacceptable thoughts dimension in exploring possible CBT techniques, instead of detailing treatment strategies and examples specific to P-OCD. Furthermore, our review of the related extant scientific literature yielded only a case report of a married, 35-year-old father of two children who presented at a psychiatry clinic with distressing intrusions of sexual aggression toward his son (O’Neil, Cather, Fishel, & Kafka, 2005), as well as a review article about repugnant obsessions in general that referenced this case in a cursory discussion of P-OCD (Moulding, Aardema, & O’Connor, 2014). Therefore, no work has yet been published with P-OCD as its dedicated focus, with specific recommendations about the use of existing measures and methods to assess for such symptoms, details on how to differentiate P-OCD from pedophilic disorder in the diagnostic process, as well as content examples for clinicians to incorporate into appropriately tailored exposure therapy for clients with P-OCD. We address these gaps here.

The examples and recommendations contained within this manuscript are intended to demystify this often misunderstood OCD subtype for clinicians and researchers. Psychiatrists, social workers, psychologists, sex therapists, and many others working with those who report unusual and inappropriate images and/or thoughts involving children will benefit from learning to differentiate between pedophilic disorder and pedophilia-themed OCD.

**Obsessions in P-OCD**

As previously mentioned, sexual obsessions in OCD can manifest as P-OCD. Clients with P-OCD typically fear that they are sexually attracted to children, including their own, if they have any. Some may also fear that they will commit sexual crimes against children, either consciously or unconsciously. Essentially, clients with P-OCD suffer from recurring mental thoughts and images of children in sexualized contexts, which elevate doubts about whether they will engage in acts of sexual violation toward them (e.g., O’Neil et al., 2005). It is important to remember, however, that one of the ways P-OCD is distinct from pedophilic disorder is that the intrusions in P-OCD are ego-dystonic (i.e., distressing) and cause severe shame, disgust, and anxiety in sufferers (Gordon, 2002). In contrast, in pedophilic disorder, the thoughts are usually ego-syntonic (i.e., clients with pedophilic disorder enjoy and are sexually aroused by sexualized thoughts and images of children). Clients with P-OCD fear that they may actually enjoy or find pleasure in these images. As a result, clients with P-OCD can spend several hours throughout the day worrying about the possibility of pedophilic tendencies. Additionally, clients with P-OCD tend to endorse high impairment and dysfunction in professional, academic, and social/interpersonal contexts, because of the amount of time and mental resources they devote instead to their pedophilia-themed worries (Moulding et al., 2014).

**Compulsions in P-OCD**

Clients who suffer from P-OCD tend to engage in many types of repetitive rituals, whether overt or covert. For OCD in general, mental compulsions are a common group of covert repetitive rituals. However, individuals with covert compulsions may be erroneously labeled as “pure obsessional,” because of the lack of observable physical or behavioral rituals (e.g., Baer, 1994). While no studies have yet been conducted to determine exactly which types of compulsions are most common among P-OCD sufferers specifically, recent research has indicated mental compulsions or rituals to be very common among individuals with unacceptable thoughts in general, consistent with clinical observations (Williams et al., 2011, 2013). Drawing from available literature and our clinical experience, we describe a few types of covert and overt compulsions that have been observed in clients with P-OCD.

**Mental Compulsions**

Covert, mental compulsions in P-OCD often include excessive mental review of one’s interactions with children (Moulding et al., 2014). The mental review process may involve mentally replaying past scenarios or situations in which children were
present, in order to check for any sexually inappropriate thoughts or actions during one’s interactions with or around children. Clients with P-OCD who engage in mental review may ask themselves questions such as, “When I was talking to that little boy, did I think about or look at his genitals?” or “When I was changing my daughter’s diaper, did I look or touch her vagina longer than necessary?” Mental review of interactions with children can haunt clients with P-OCD as they attempt, albeit unsuccessfully, to ascertain whether or not they have violated the children sexually. Although it seems reasonable that repeated checking will facilitate more confidence in one’s convictions, research shows that repeated checking tends to reduce the clarity of, and hence confidence in, one’s memory for any particular event, both in people with and without OCD (Hout & Kindt, 2004; Radomsky & Alcolado, 2010; Radomsky et al., 2006). In some cases, the backfiring effects of mental review of a perceived pedophilic event can even be the trigger that brings P-OCD symptoms to their peak. P-OCD sufferers who engage in mental review can spend a lot of time that could otherwise be devoted to other daily activities trying to convince themselves that they did not commit pedophilic acts. Unfortunately, time wasted in mental review paradoxically increases anxiety in the long run and strengthens clients’ P-OCD symptoms, due to the exaggerated significance that they, by virtue of their mental compulsions, attach to their pedophilia-themed worries.

Rumination, whether focused on the probable causes, situational factors related to, or legal and social implications of their self-perceived pedophilic behaviors, also occurs in clients with P-OCD. Because rumination elicits strong emotional reactivity to their pedophilia-centric thoughts, clients with P-OCD are likely to constantly question themselves about whether or not they are actually pedophiles (e.g., O’Neil et al., 2005). Rumination in P-OCD, in this sense, appears to be linked to the use of mental review in an attempt to achieve some form of resolution of this uncertainty, or some semblance of confirmation that no sexually inappropriate or perverse actions occurred in interactions with children. These mental compulsions alleviate anxiety only temporarily; when doubt about self-perceived pedophilic tendencies reenters the mind, the self-reinforcing cascade of mental compulsions restarts.

Other mental compulsions may involve repeating certain words, phrases, or visual images multiple times, in an effort to soothe or distract oneself from triggering situations and events (Sibrava, Boisseau, Mancebo, Eisen, & Rasmussen, 2011). For example, one male client in our clinic had suffered from pedophilia-themed obsessions involving his daughter and would repeat the word “Facebook” in his mind several times, whenever he experienced upsetting, pedophilia-themed intrusions and related triggers. He referred to the word “Facebook” as his “safe word” as it was associated with positive family-related feelings that seemed to counter his disturbing obsessions about his daughter. To him, mentally repeating his “safe word” provided distraction and somewhat reduced his anxiety. The client also reported inserting “safe images” into his mind whenever intrusive sexual mental images about his daughter arose. Specifically, he would immediately think of and hold an appropriate, non-sexual image of his daughter in his mind to try to cancel or block out the disturbing one. For example, if an intrusive sexual image of his daughter came to mind, he would attempt to replace that with a “safe image” of his daughter sitting in a chair smiling. He would also sometimes try to replace any intrusive sexual image of his daughter with an image of his wife’s face. According to the client, these “safe images” allowed him to defuse his obsessions and move forward with whatever task was interrupted by the disturbing obsessions. In these examples, the act of intentionally replacing a negative thought or image with something good or positive perhaps serves the function of mentally “undoing” the anxiety-provoking obsessions, in order to prevent their contents from becoming reality (see Starcevic et al., 2011). However, similar to the backfiring effects of mental review, these mental compulsions ironically strengthen the pedophilia-themed obsessions, because of the excessive attention and inflated personal significance attached to them and negative reinforcement experienced in the moment.

Somatic Checking

Somatic checking in OCD refers to checking one’s body for sensations, often in response to OCD-related stimuli or triggers. Clients who suffer from other forms of OCD may also engage in somatic checking (e.g., in sexual orientation-themed OCD or SO-OCD; Williams, Slimowicz, Tellawi, & Wetterneck, 2014b; Williams, Tellawi, Davis, & Slimowicz, 2015). However, clients with P-OCD may specifically check their body for signs of sexual arousal or attraction to children. In the somatic checking process, any physical sensation or movement experienced in the genital region in the presence of children and/or during pedophilia-themed obsessions may be misinterpreted as a sign of sexual arousal or attraction. For example, a father with P-OCD may be overly cautious while changing his child’s diaper, because of the fear that he may be sexually aroused by this otherwise innocuous act. During diaper changes, he may be hypersensitive and excessively focused on sensations in his genital region. This exaggerated attention to his genital region can in turn—and expectedly so—result in vague genital sensations, therefore providing (erroneous) “evidence” of his worst fear. In another example, allowing a child to sit on a P-OCD client’s lap would be highly anxiety-provoking, because of the close proximity between the client’s genitals and the child’s body. The principal fear here is that sexual pleasure would be derived from this close contact, in addition to the possible perception that serious sexual harm would be inflicted on the child as a result of what the client views as inappropriate physical contact.
Reassurance-Seeking

Due to the taboo nature of unacceptable thoughts, such as obsessions about sexual harm toward children in P-OCD, clients often seek reassurance in various forms to try to reduce the anxiety elicited by the intrusive thoughts (Calvocoressi et al., 1995; Williams et al., 2011). Reassurance-seeking can take many forms, including constantly reassuring the self, persistently seeking reassurance from others, confessing to others, or compulsively searching the Internet and/or scrutinizing relevant reading materials for explanations for one’s obsessions (Williams et al., 2011). In P-OCD, for example, clients will often compulsively ask parents, other family members, spouses/partners/significant others, and close friends about whether or not they have committed a sexually inappropriate act toward a child who may have been in close proximity at a recent event. Typically, clients with P-OCD will continue to seek reassurance about the absence of sexual harm toward a child in an event that occurred several months or even years ago. While clients perceive obtaining reassurance as morally necessary, it causes much family stress because of the strain put on loved ones who become targets for reassurance (Calvocoressi et al., 1995).

Avoidance

In order to prevent the manifestation of self-perceived pedophilic tendencies, clients with P-OCD may avoid children at all costs. Avoidance of triggering objects and other related stimuli (e.g., baby strollers, maternity magazines, children’s cartoons, television shows and movies with child actors or about child molestation, news articles about convicted pedophiles) is also very common among clients with P-OCD. Additionally, there are a variety of other scenarios or situations that sufferers may avoid to prevent distress. Some of these include being alone with children (even children they are related to or directly responsible for), and actually touching or looking at children. However, engaging in avoidance behaviors that clients with P-OCD erroneously believe will protect children from the sexual abuse they fear they may perpetrate will only serve to maintain the disorder. This is, again, due to the inordinate personal significance associated with such fears that paradoxically strengthens these obsessions and the relief experienced upon fleeing the feared situation. Steering clear of children only increases dysfunction in P-OCD. For example, a mother with P-OCD may avoid seeing her child naked for extended periods of time. She may have to suffer through diaper changes and bath time and may rush through these activities to avoid looking at parts of her child’s body (e.g., genitalia) that she fears might cause her to become very anxious. She may also shirk her duties to bring her child to school, recitals, or soccer games where other children are also present, possibly leading to spousal discord. Although avoidance is not necessarily considered a compulsion, it does, as mentioned, serve the same maladaptive function of reinforcing the perceived danger of pedophilia-themed obsessions, as well as the need to control or neutralize them.

Assessment of P-OCD Symptoms

Assessment Using Clinical Measures

Many clients enter treatment presenting with OCD symptoms in the other more extensively researched symptom dimensions, so it is likely that commonly used measures will be able to adequately detect and assess these symptoms. However, it can be difficult to assess for P-OCD symptoms as there are few measures that adequately screen for or measure sexual obsessions or other types of taboo and repugnant obsessions. Nonetheless, there are a few viable options.

The Yale–Brown Obsessive–Compulsive Disorder Scale—Second Edition (Y-BOCS-II; Storch et al., 2010) is a gold standard measure of past and current (i.e., within the past 30 days) OCD symptoms and their severity among clients diagnosed with OCD, having demonstrated good psychometric properties in terms of reliability and validity in the original validation study with a sample of 130 OCD patients. In the Symptom Checklist component of the Y-BOCS-II that is divided into items assessing obsessions, compulsions, and avoidance, there are a few items that attempt to capture P-OCD concerns. For example, Items 18 and 19 (“forbidden or improper sexual thoughts or images” and “experiences unwanted sexual impulses”) assess for pedophilia-themed obsessions explicitly, while Items 9 and 10 (“fear might harm self or others because not careful enough” and “fear might harm self or others on impulse”) may uncover obsessions about feared, unintentional sexual violation of children, if accompanied by appropriate probing and requests for elaboration. Items assessing compulsions seem to tap into the mental compulsions and reassurance-seeking commonly observed in clients with P-OCD (e.g., Items 44 and 55: “asking for reassurance” and “mental rituals [other than checking or counting!]”). There are also items applicable to avoidance behaviors seen in P-OCD (e.g., Items 59 and 62: “avoids doing things, going places or being with someone because of obsessions” and “avoids contact with people, children or animals because of unwanted impulses”). If clients endorse P-OCD symptoms through these items, the impact of such symptoms on clients’ functioning can then be assessed using the ten-item Severity Scale component of the Y-BOCS-II. Total scores range from 0 to 50, with higher numbers indicating greater severity.

Another option is the Obsessive–Compulsive Inventory—Revised (OCI-R; Foa et al., 2002). The OCI-R is an 18-item, self-report instrument that assesses the degree of distress associated with washing, obsessing, hoarding, ordering, checking, and neutralizing symptoms in the past month on a five-point Likert scale, with higher scores indicating greater OCD symptom severity. The OCI-R has demonstrated sound psycho-
metric properties and appears to be useful for assessing OCD symptoms in clinical samples (e.g., Huppert et al., 2007). Unfortunately, the OCI-R does not contain any items that specifically and explicitly assess for P-OCD concerns. It does, however, contain two thematically broad items (i.e., Items 12 and 18: “I am upset by unpleasant thoughts that come into my mind against my will” and “I frequently get nasty thoughts and have difficulty in getting rid of them”) which P-OCD sufferers may endorse. Clinicians should then encourage clients to elaborate on what these endorsements refer to, in order to ascertain the presence of P-OCD concerns.

Lastly, the psychometrically sound, 20-item Dimensional Obsessive–Compulsive Scale (DOCS; Abramowitz et al., 2010) assesses OCD symptom severity on the basis of four symptom dimensions pertaining to contamination-related concerns, responsibility for harm, unacceptable thoughts in general, and concerns about symmetry/completeness. For each symptom dimension, a brief description and examples of related obsessions and compulsions are included for respondents to read before responding. Thereafter, individuals rate their severity on five five-point-scale items assessing: (1) the amount of time spent on obsessions and compulsions; (2) extent of avoidance of triggers; (3) degree of distress from symptoms; (4) level of functional interference; and (5) difficulty disregarding obsessions and refraining from acting on compulsions. Therefore, in terms of assessing P-OCD concerns, the Unacceptable Thoughts subscale of the DOCS appears to fare better than the two items on the OCI-R due to its more elaborated emphasis on unacceptable thoughts. In fact, there is even a more specific version of this subscale that targets sexual obsessions. Wetterneck, Siev, Adams, Slimowicz, and Smith (2015) adapted the contents of the Unacceptable Thoughts subscale of the DOCS in developing the 5-item Sexually Intrusive Thoughts Scale (SIT), in order to target overall severity of a wide range of sexual obsessions (e.g., obsessions about rape and other forms of sexual violence toward others, SO-OCD concerns, P-OCD concerns). This new scale has exhibited good psychometric properties and appears to be distinct from the Unacceptable Thoughts subscale of the DOCS. If the DOCS and SIT appeal to clinicians, we recommend that clinicians first use the DOCS to assess OCD symptoms comprehensively. If P-OCD concerns surface upon review of clients’ responses, we recommend clinicians to then use the SIT to more accurately assess P-OCD symptom severity, to avoid conflating with violent and blasphemous obsessions that are also targeted by the Unacceptable Thoughts subscale of the DOCS. That being said, to date there has been no research to determine which measures are most effective in identifying P-OCD.

**Assessment Using a (Semi-)Structured Interview**

Participating in the assessment process can be especially challenging for clients experiencing pedophilia-themed obsessions, primarily due to the disturbing and stigmatized contents of their problematic thoughts and the need to disclose them. Clients may have already suffered negative experiences with previous treatment providers after disclosing their P-OCD concerns. Because of this possibility, greater sensitivity and well-informed clinical judgment must be exercised when assessing for P-OCD in a (semi-)structured interview. Being cognizant of the element of ego-dystonicity in such thoughts, as well as the particular mental and/ or behavioral compulsions that can occur in P-OCD, can help in this process. There are a few comprehensive (semi-)structured interview instruments available to assess for P-OCD to varying extents.

The mini-international neuropsychiatric interview (M.I.N.I.; Sheehan et al., 1998), now in its seventh edition in English, is a brief, fully structured diagnostic interview currently validated against criteria for major psychiatric disorders contained in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; APA, 1994) and the tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10; World Health Organization [WHO], 2010). It takes approximately 15–20 min to administer and contains a module to screen for OCD symptoms. However, this module is more likely to capture more well-known presentations, like contamination-related concerns. For example, while the section on obsessions does include some verbiage that may signal intrusive, ego-dystonic sexual thoughts (and, in fact, comes with a prompt for the interviewer to exclude excessive worries about the negative consequences of genuine sexual deviations that clients otherwise find pleasure in), the section of the module devoted to compulsions does not adequately capture mental compulsions typically observed among unacceptable/taboo forms of OCD. Instead, the M.I.N.I. mostly targets physical compulsions (e.g., direct queries about whether or not clients repeatedly wash their hands or otherwise clean excessively), which tend to be more frequently seen in more widely known forms of OCD. Therefore, although time-efficient, the M.I.N.I. may not be optimal for uncovering the full range of P-OCD symptoms in any particular client.

A widely used semi-structured diagnostic interview used to assess for OCD is the Structured Clinical Interview (SCID), now in its latest research (SCID-5-RV; First, Williams, Karg, & Spitzer, 2015a) and clinician versions (SCID-5-CV; First, Williams, Karg, & Spitzer, 2015b), which were developed in accordance with criteria for major psychiatric disorders established in the fifth edition of the DSM (DSM-5; APA, 2013). Interviewers need to be adequately trained in its administration due to its length and complexity. After assessing for the presence of obsessions and/or compulsions, the SCID’s module for OCD approaches diagnosis in general terms. Specifically, there are questions about whether clients engage in obsessive thoughts more than they think is normal and/or whether any act on compulsions more than they think they should. These questions seek to assess clients’ level of insight into whether the time spent on obsessions and compulsions is excessive. The OCD module
then requires clients to quantify the level of impairment they experience by asking how often other life tasks are interrupted by their OCD symptoms, as well as how much anxiety is experienced during an obsessive–compulsive episode. However, the adequacy of the SCID in detecting P-OCD remains questionable, mainly because it does not inquire specifically about sexual obsessions pertaining to pedophilia-themed concerns. As such, P-OCD symptoms may be missed entirely in the diagnostic process.

Another semi-structured diagnostic interview that can be used to assess for OCD is the Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5; Brown & Barlow, 2014). Again, due to its length and complexity, interviewers need to be adequately trained in the administration of the ADIS-5. Similar to the SCID, in the ADIS-5’s module for OCD, there are questions that assess clients’ symptom severity, level of insight, amount of resistance against obsessions and compulsive urges, and the extent of avoidance of triggering stimuli and situations. However, the ADIS-5 does a better job than the SCID in assessing for different manifestations of OCD. Specifically, the OCD module in the ADIS-5 provides a more comprehensive range of obsessions and compulsions for clients to endorse by listing different OCD symptom dimensions. Although it does not specifically mention P-OCD symptoms, a client with pedophilia-themed obsessions and compulsions may still likely relate to the sections concerned with “unwanted sexual thoughts/images” and/or “aggressive urges.” Additionally, the section designed to capture compulsions mentions “internal repetition,” which may account for covert rituals like mental compulsions. Therefore, to maximize its potential for assessing many important symptom manifestations in a client with P-OCD, interviewers using the ADIS-5 will be well served by being informed about the different symptoms, particularly mental compulsions, as well as compulsive somatic checking and reassurance-seeking, that are prototypical of P-OCD. One drawback, however, is that the format of the ADIS-5 can be cumbersome for the interviewer.

**Assessment Using a Clinical Interview**

An unstructured clinical interview is often the best clue for clinicians that a client is presenting with P-OCD. Nonetheless, many clients with P-OCD who seek treatment are reticent to disclose the taboo thoughts they have been having out of shame or fear of legal or social punishment that they believe will accompany this disclosure (Cathey & Wetterneck, 2013; Newth & Rachman, 2001). In most cases, clients have already done copious amounts of online research to determine the root cause for the manifestation of intrusive pedophilia-themed thoughts. Despite having recognized their symptoms as constituting OCD, many clients still resist the idea that they are suffering from a mental disorder. Instead, they may feel they should be blamed and punished for having such thoughts. Therefore, whenever clients broach topics with pedophilic themes in relation to their presenting issues, clinicians should be sensitively attuned to their hesitation (if any) and be encouraging and non-judgmental in their requests for clarification or elaboration of these topics. For example, it may be helpful for clinicians to normalize the presence of unacceptable thoughts by explaining that all people experience unpleasant and distasteful thoughts on occasion. If the client has difficulty verbalizing their obsessions, it may be helpful for the clinician to begin describing some common obsessions that have been disclosed by other clients with P-OCD. For example, the clinician may say, “Some people with unacceptable/taboo forms of OCD may experience upsetting thoughts about children or may see themselves in inappropriate situations with children.” It is important to ensure that the client understands the clinician’s description is meant to be broad and general, and not one that necessarily represents their specific obsessions. Developing good rapport with clients throughout the assessment can also facilitate more forthcoming disclosure.

Once clients feel confident and safe enough to open up about their obsessions involving pedophilic themes, they may sometimes begin with a thorough backstory detailing the plausible events that may have triggered these thoughts. Throughout this narrative, clinicians may repeatedly hear clients state adamantly that they never had these issues in the past when in the presence of children. Clients may also ask repeatedly for reassurance from clinicians (e.g., “Do you think I am a pedophile?”). It is highly likely that although the numerous times clients are or have been reassured that they are not in fact pedophiles, both in and outside of a clinical setting, they will continue to doubt this information. Clients may also express feeling as though they did not give enough information to help clinicians really determine whether they are actually pedophiles. Getting a detailed history of treatment(s) they may have received in the past is useful, as many clients may have sought treatment (or at least a diagnostic assessment) from several other providers as a form of compulsive reassurance-seeking, despite the initial discomfort in disclosure.

It is important to note that clients with P-OCD feel distress specifically because of the fear that they are horrible people who are sexually attracted to children, and/or that they are likely to commit sexual harm toward children, even though they are extremely disinclined to do so. They have not actually committed pedophilic crimes and are highly disturbed by intrusive pedophilia-themed thoughts and images. Importantly, they do not experience any pleasure when these thoughts and images persist. Instead of approaching children, they may go to great lengths to avoid contact with children. Sometimes, these fears go much further than that of being sexually attracted to children. Many clients go on to worry that they will be deserted by their loved ones and be imprisoned indefinitely. Some others may decide that they will never have children and that they should never be around children due to their worries about sexually harming children unknowingly. It is unfortunate that many clients prematurely make very definite decisions about their lives because of these fears. Therefore, a differential diagnosis from pedophilic disorder is crucial in the assessment process, not only to aid in proper...
treatment, but also to destigmatize these thoughts and their effects on important life decisions for clients with P-OCD.

**Differential Diagnosis**

Despite the availability of certain assessment tools and methods to detect P-OCD to varying extents, the disorder is frequently misdiagnosed. For example, a recent study assessed clinicians’ ability to correctly identify common symptom presentations of OCD (Glazier et al., 2013). All participants were members of the American Psychological Association and were randomly recruited across the 50 states. Of the participants, 81.8% were doctoral-level psychologists, 81.3% were licensed, and over half reported a CBT orientation. Each participant was instructed to provide a diagnostic impression of one out of five randomly assigned OCD symptom vignettes. Results indicated that 42.9% misidentified sexual obsessions about children, with over a third wrongly classifying the problem as pedophilia. In contrast, only 15.8 and 28.8% misidentified contamination-based and religious obsessions as being indicative of OCD, respectively. Primary care physicians fared even worse, with 70.8% misdiagnosing P-OCD (Glazier, Swing, & McGinn, 2015). This disproportionately high degree of misidentification of P-OCD symptoms, even among trained professionals, calls into question the likelihood that people with P-OCD will obtain a proper diagnosis and appropriate treatment.

In another unfortunate example from our clinic, a male client experiencing severe pedophilia-themed obsessions about his daughter described in the intake session how he became so overwhelmed with the intrusive thoughts and images that his wife escorted him to the emergency room. After the client described his obsessions, the psychiatric staff, being unaware of the distinctions between P-OCD and pedophilic disorder, reported him to Child Protective Services, which resulted in restrictions on his contact with his daughter. Naturally, these events were traumatic for the client and his family. Had the psychiatric staff at the hospital been knowledgeable about P-OCD and its distinctions from pedophilic disorder, this client could have avoided these unnecessary consequences. It is highly possible that many clients face ridicule and scrutiny when trying to find help, due to the apparent poverty of knowledge about P-OCD in clinical practice. Therefore, the onus is on clinicians to be aware of the presentation of this form of OCD, in order to accurately obtain a differential diagnosis from pedophilic disorder.

There are significant distinctions in presentation between a genuine pedophile and one who suffers from P-OCD (Purdon, 2004), as shown in Table 1. The term “pedophile” refers to an individual who suffers from pedophilic disorder, in which there is a strong, dysfunctional sexual attraction to children, which may include child molestation. When individuals with pedophilic disorder come in contact with children, they are likely to experience sexual arousal toward them. Any fear or anxiety about this sexual attraction is likely attributable to society’s criminalization of those who prey on children sexually, rather than the awareness of their desire to become intimately close to children. Additionally, individuals with pedophilic disorder tend to prefer the company of children, instead of age-appropriate companions. Furthermore, individuals with pedophilic disorder are likely to engage in grooming behaviors toward a child by finding opportunities to gain their trust. For example, they may feign interest in activities that the child enjoys, and may slowly get the child more comfortable with inappropriate touching by creating opportunities to play-fight or wrestle with the child. They may also seek opportunities to be alone with their victims, leading to more intimate, inappropriate touching. Individuals with pedophilic disorder experience sexual gratification from child grooming interactions (Lang & Frenzel, 1988).

In sharp contrast, clients with P-OCD do not find the contents of their obsessions pleasant or sexually arousing. Instead, clients experiencing obsessions about sexual contact with children are repulsed by these sexually explicit thoughts and graphic images. Additionally, clients with P-OCD are generally avoidant of children. They may take extreme measures to avoid contact with even their own children. They may even isolate themselves away from others, in order to decrease the perceived likelihood that they may sexually violate or molest a child. Notably, as observed in our clinic, many clients with P-OCD state that they would rather commit suicide than hurt a child. Despite these stark differences, many uninformed treatment providers misdiagnose P-OCD clients’ symptoms as pedophilic disorder and proceed to subject these clients to legal entanglements, which only exacerbate their symptoms and confirm their worst fears. Clinicians who are unsure as to whether a client is experiencing P-OCD should ask the client to describe their interaction with children. For

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<th>Table 1 Differential diagnosis: P-OCD versus Pedophilic Disorder</th>
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<td><strong>Pedophilic disorder</strong></td>
</tr>
<tr>
<td>Sexual attraction to children</td>
</tr>
<tr>
<td>Prefers the company of children and desires to be intimately close with them</td>
</tr>
<tr>
<td>Performs grooming behaviors toward children for sexual contact</td>
</tr>
<tr>
<td>Experiences sexual gratification from sexual contact with children</td>
</tr>
</tbody>
</table>


example, one may ask, “Tell me about the last time you had a conversation with a child” or “How often do you spend time with children?” It may also be helpful to assess their reactions to interactions with children by asking, “What is it like for you to be around children?” In our clinic, clients with P-OCD rarely experience positive reactions when in close proximity to a child and will often describe unpleasant emotional and physiological symptoms as a result.

DSM-5 criteria allow the diagnosis of pedophilic disorder in individuals who have not aggressed against children if their sexual urges are intense or distressing (APA, 2013). Indeed, there are some with a pedophilic sexual orientation who chose not to act on these urges. Such individuals may be distressed about their attraction to children due to their own personal morals or religious beliefs, and in such cases it could be said that the pedophilic urges are ego-dystonic. It can be difficult to differentiate between ego-dystonic pedophilia and P-OCD. The level of sexual arousal caused by children is a key distinguishing feature between pedophilic disorder and P-OCD. To determine this, clinicians may ask questions like, “Do your sexual fantasies include young children?”, “Are you more sexually aroused by images of children or images of adults?”, and “Do you ever masturbate to thoughts or images of children?” The use of child porography is a strong diagnostic indicator of pedophilic disorder (APA, 2013). This line of questioning, however, will be alarming to people with P-OCD, who may then become concerned that the clinician may perceive them to be sexually deviant.

One might wonder if phallicommetric assessment, or plethysmography, could assist with differential diagnosis. One issue with this approach is that those with P-OCD will often become sexually aroused by “forbidden” images simply because of heightened anxiety. Indeed, many with P-OCD complain of physical sensations they refer to as a “groinal response,” and experience embarrassment and fears about what it could mean. Physiological reactions can include increased heart rate, sweating, and some degree of tumescence or lubrication, which the sufferer then misinterprets as an indication of desire or intent. For this reason, it is possible that the very process of phallicometric assessment may cause overwhelming anxiety and distress in such clients. Most phallicometric research has been focused on identifying risk in sex offenders (McPhail et al., 2017), so at the present time there is no research to support the use of such techniques for identifying anxiety-related conditions. However, differences in plethysmographic findings between people with pedophilic disorder and P-OCD is an interesting area of inquiry that warrants further research.

**Treatment with Exposure and Response Prevention**

Exposure and response prevention (Ex/RP) has been supported as an effective, evidence-based treatment program for OCD in adults and children (Abramowitz, Taylor, & McKay, 2009; Abramowitz, Whiteside, & Deacon, 2005; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, Marín-Martínez, 2008; Williams, Powers, & Foa, 2012). As a form of CBT, Ex/RP consists of specific interventions targeting the affective, behavioral, and cognitive bases of OCD symptoms, including psychoeducation, in vivo and/or imaginal exposures, and response prevention (Foa et al., 2012). At the core of Ex/RP is the process of confronting OCD-related triggers that typically induce distress (i.e., exposure), while refraining from acting on compulsive urges to ritualize that usually function to reduce that distress (i.e., response prevention). In doing so, overtime, the self-reinforcing cycle of obsessions and compulsions will be broken. Traditionally, the way that Ex/RP is thought to work in treating OCD is through repeated sessions in which clients gradually habituate to the distress evoked by exposure to OCD-related stimuli without acting upon their triggered compulsions, resulting in the eventual extinction of obsessional distress and associated urges to ritualize (Abramowitz, Deacon, & Whiteside, 2011; Foa et al., 2012; Huppert & Roth, 2003). However, other mechanisms have been proposed, including inhibitory learning and cognitive flexibility (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014; Twohig, Whittal, Cox, & Gunter, 2010). While there are adequate cognitive treatments for OCD, our article will specifically focus on the use of Ex/RP to decrease OCD symptoms.

While Ex/RP has been found to be effective for treating OCD in general, clients with P-OCD may require more treatment sessions than other forms of OCD, due to the guilt, shame, and moral repugnance associated with having obsessions of this nature. In fact, studies have found that clients with sexual obsessions are more treatment-resistant than those with other forms of OCD. For example, Williams et al. (2014a) found that although clients improved substantially, those with unacceptable thoughts improved less when treated with Ex/RP, compared to other OCD symptom dimensions. Additionally, a long-term follow-up study of OCD clients treated with medication and behavior therapy showed that sexual and religious obsessions were uniquely predictive of poorer treatment outcomes over time (Alonso et al., 2001). One reason unacceptable/taboo forms of OCD is more difficult to treat may be due to the high levels of distress these clients experience, making it difficult for clients to become fully compliant during the treatment process. Additionally, the mental compulsions and reassurance-seeking behaviors that predominate in clients with unacceptable/taboo forms of OCD are often missed by mental health professionals (Williams et al., 2011). The following sections will discuss the primary components of Ex/RP and how it can be applied to P-OCD, with the aforementioned considerations in mind.

**Psychoeducation**

Providing clients with psychoeducation prior to implementing Ex/RP is vital. Psychoeducation can first involve normalizing clients’ P-OCD symptoms by educating them on the prevalence of unwanted sexual thoughts, that such thoughts are a common
occurrence in the general population (Rachman & de Silva, 1978), and that they should not be afraid of discussing them openly in therapy. Communicating that the mere existence of such thoughts is not an indication of sexual deviance can often be the first step in decreasing clients’ distress.

It is also helpful for clients with P-OCD to understand that they experience such great distress because they may tend to catastrophically misinterpret unwanted pedophilia-themed thoughts as particularly dangerous and/or revelatory of their “true nature” (Rachman, 1997, 1998; Salkovskis, 1985, 1999; Wetterneck, Smith, Hart, & Burgess, 2011). This discussion can be linked to elaboration of the cognitive processes that may contribute to P-OCD. For example, thought–action fusion (TAF) refers to a set of irrational beliefs that having certain thoughts will make one more likely to commit acts in accordance with the thoughts, or that such acts have already been committed simply by having such thoughts (Shafran, Thordarson, & Rachman, 1996). Clients with P-OCD who strongly endorse TAF beliefs will misinterpret their pedophilia-themed thoughts as indicative of a desire to sexually harm children, an increased likelihood of actually committing such acts, or even the erroneous conclusion that they must have already sexually harmed children in the past. Such beliefs are subsumed under the broader cognitive domain of overimportance of thoughts (Obsessive Compulsive Cognitions Working Group, 2005), which has been shown to have some specificity to unacceptable obsessions (Wheaton, Abramowitz, Berman, Riemann, & Hale, 2010). Specifically, clients with P-OCD who strongly endorse overimportance of thoughts ascribe exaggerated personal significance to their pedophilia-themed obsessions and, as a result, manage these obsessions maladaptively with compulsions. Similarly, clients with P-OCD can also engage in compulsions to address their distressing obsessions when they overestimate the threat of their pedophilia-themed thoughts for committing sexual harm toward children, or when they are unable to tolerate the uncertainty of whether or not they are actually pedophiles (Viar, Bilsky, Armstrong, & Olatunji, 2011). Other maladaptive thought control strategies can also maintain P-OCD. For instance, when clients with P-OCD experience thoughts about inappropriately touching children, they tend to try to suppress such thoughts (Wegner, Schneider, Carter, & White, 1987), and/or blame themselves as self-punishment (Jacoby, Leonard, Riemann, & Abramowitz, 2016), which paradoxically increases the frequency of such thoughts due to their increased personal significance and perceived danger. This is in sharp contrast to how individuals without OCD are able to easily dismiss unwanted thoughts without resorting to such strategies. Therefore, providing psychoeducation on the dysfunctional cognitive processes relevant to P-OCD can decrease clients’ misevaluation of their thoughts and their meaning and importance, helping them view their unwanted thoughts in a more realistic manner (see Whittal, Woody, McLean, Rachman, & Robichaud, 2010).

Furthermore, psychoeducation also includes discussion of the functional relationship between obsession and compulsions, to provide further insight into how their symptoms are maintained. Clients can be educated on how, for example, mental compulsions, which often provide initial relief from the distress caused by pedophilia-themed obsessions, unfortunately backfire in the long term by reinforcing the OCD cycle, making the recurrence of such obsessions more likely, consequently increasing levels of functional impairment. Clients can also be made aware that Ex/RP seeks to disrupt this relationship between obsessions and compulsions, to bring about symptom improvement.

Lastly, psychoeducation informs clients about the process of Ex/RP and explains the rationale for employing this treatment. A detailed rationale is imperative prior to implementing Ex/RP, because many clients are disinclined to participate due to the aversive nature of exposures. Helping clients understand the reasons for and evidence behind Ex/RP plays a key role in preparing them for the treatment and increasing compliance throughout the course of Ex/RP (Piacentini et al., 2011). For example, clients can be informed that the response prevention component of Ex/RP seeks to alter their behavioral and affective responses to triggering stimuli and distressing obsessions in order to weaken the OCD cycle, which will also bring about a change in cognitive processes related to the maintenance of their P-OCD symptoms. Furthermore, clients should be informed of all specific aspects of Ex/RP, such as the use of a subjective units of distress scale (SUDS) to quantify and track changes in the intensity of anxiety experienced throughout the treatment process (Wolpe, 1969).

In Vivo Exposures

In vivo exposures involve confronting actual stimuli or situations that trigger OCD symptoms and should be tailored to address the core obsessional fears of clients with P-OCD (e.g., being sexually attracted to children, and/or that one is capable of sexually harming a child accidentally or intentionally, resulting in criminal prosecution or public censure). Prior to conducting in vivo exposures, clinicians and clients should collaborate to identify and rank obsessional triggers based on client-reported SUDS ratings. This allows for an in vivo exposure hierarchy to be created, starting from the least distressing trigger to the most distressing one. Table 2 illustrates a sample hierarchy developed for a male P-OCD client whose core fear revolved around sexually abusing his infant daughter. It is also helpful to identify compulsions (particularly mental rituals) and avoidance behaviors for each trigger if possible, in order to address these behaviors whenever they surface during in vivo exposure.

Initial in vivo exposures should occur in-session with clinicians guiding clients through the exposure. Clinicians should start with a moderate-SUDS trigger on the hierarchy, before confronting more distressing triggers (Barlow, 2014). For example, clinicians can begin treatment with a hierarchy item rated at a SUDS level of 45, such as having clients write “I am a pedophile” repeatedly on a sheet of paper. This allows for flexibility in moving down the hierarchy should the initially chosen trigger be too daunting for the client to start with. During the exposure, clin-
propriety, clinicians should monitor clients for rituals and/or avoidance behaviors, such as joking about the task or not focusing directly on the words they are writing because their attention is distracted by the performance of mental compulsions (Gillihan, Williams, Malcoun, Yadin, & Foa, 2012). Clients should engage in exposures for approximately 30–60 min, or until their SUDS levels for the trigger have decreased to at least half of the peak level of anxiety. Longer exposures allow more time for habituation; more intensive or pervasive obsessions may require longer periods of time to achieve habituation (Foa & Kozak, 1986). Once clients have habituated to lower- and moderate-SUDS triggers, clinicians can then move clients up the hierarchy to more challenging and distressing exposures.

Table 2  Sample in vivo exposure hierarchy

<table>
<thead>
<tr>
<th>Exposures</th>
<th>SUDS</th>
</tr>
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<tbody>
<tr>
<td>1. Eating food shaped like female genitalia (e.g., pizza, wedge of cheese)</td>
<td>35</td>
</tr>
<tr>
<td>2. Looking at a picture of children in bathing suits</td>
<td>40</td>
</tr>
<tr>
<td>3. Watching a movie containing brief sexual violence</td>
<td>50</td>
</tr>
<tr>
<td>4. Eating food that reminds client of male genitals (e.g., a banana)</td>
<td>60</td>
</tr>
<tr>
<td>5. Changing daughter’s diaper while in presence of wife</td>
<td>60</td>
</tr>
<tr>
<td>6. Watching a music video with a little girl dancing (e.g., “Elastic Heart” by Sia)</td>
<td>70</td>
</tr>
<tr>
<td>7. Holding daughter on lap</td>
<td>75</td>
</tr>
<tr>
<td>8. Writing a story about becoming a pedophile</td>
<td>80</td>
</tr>
<tr>
<td>9. Watching a sexually explicit movie</td>
<td>80</td>
</tr>
<tr>
<td>10. Being alone with daughter</td>
<td>80</td>
</tr>
<tr>
<td>11. Watching movie/documentary/news video clip about pedophiles</td>
<td>90</td>
</tr>
<tr>
<td>12. Bathing with daughter</td>
<td>90</td>
</tr>
<tr>
<td>13. Changing daughter’s diaper all alone</td>
<td>95</td>
</tr>
</tbody>
</table>

As anxiety decreases to specific exposures and clients move up their hierarchies, therapists should find ways to revisit exposures that were previously addressed and incorporate elements of several different fears into exposure exercises. For example, a client who previously habituated to eating foods that resemble genitalia like bananas and pizza, may then revisit this exposure by sharing these foods with a child within the context of sharing a snack with the child. Adding this extra component into the exposure increases the intensity by exposing the client to multiple contexts which invoke fear and anxiety. The client may have habituated to eating foods that resemble genitalia and being alone with a child when these exposures were done separately; however, merging them together presents a novel exposure for the client to approach. Craske et al. (2014) refer to this strategy of combining previously addressed exposures as deepened extinction in her inhibitory learning approach to enhancing exposure. Also, it should be noted that it is not always necessary for clients to habituate to a given stimulus to improve. Craske et al. recommend varying the difficulty of exposures randomly in order to promote learning, although early success is important because if anxiety becomes too high, clients may reject Ex/RP altogether. After exposures are completed in the office, therapists should take some time to discuss the experience and what was learned from it.

While many in vivo exposures take place within the therapy office, some exposures may require visits to alternative settings. For example, a client may identify “being around children” as a high-SUDS trigger. Therefore, to confront this trigger, the clinician can accompany the client to a local park or playground where children are present. While this particular exposure may be assigned as a homework activity, the clinician may need to guide the client through this process initially if it proves to be too anxiety-provoking for the client to complete alone.

Flexibility and creativity in exposure setting selection and planning are crucial to successful treatment. In addition, given the taboo nature of this form of OCD, it is very important that clinicians are comfortable working with P-OCD clients in addressing their symptoms. Specifically, clinicians need to be able to demonstrate exposures to certain taboo triggers (e.g., watching video clips containing implied sexual abuse of children) without appearing anxious or disgusted, in order to effectively model how to participate in exposures to clients.

Imaginal Exposures

Imaginal exposures are unique and effective interventions that allow clients with P-OCD to confront their obsessional fears in a way that otherwise would not be possible or plausible in the context of an in vivo exposure (Freeston et al., 1997; Gillihan et al., 2012). Imaginal exposures are often based on a script created in collaboration between clinicians and clients detailing a story about the worst possible outcomes for clients’ core obsessional fears (Foa et al., 2012). Importantly, the imaginal exposure script describes, in great detail, negative events that occur as a direct result of having the obsessions and not engaging in compulsions. When conducting imaginal exposures, clients are recommended to close their eyes and imagine the created scenario in as much visual detail as possible while being read to, or listening to a recording of, the script. Clients should also be instructed to listen to the recording of the script daily as a homework activity. Table 3 displays a sample imaginal exposure script developed for the male client with P-OCD fears of sexually abusing his infant daughter described previously.

Response Prevention

An integral component that accompanies exposures in the process of Ex/RP for P-OCD is response prevention. Response prevention, as the name suggests, refers to refraining from engaging in compulsions or rituals used to decrease anxiety resulting from an obsessive cascade triggered during exposures. Response prevention in conjunction with exposure has been found to provide
superior effects in comparison with exposure alone (Foa, Steketee, Grayson, Turner, & Latimer, 1984).

As previously noted, reassurance-seeking is a compulsion typically observed in P-OCD. For example, clients may experience the obsession, “What if I am a pedophile?” In an effort to reassure themselves, they may think, “No, I am sure I am not at all attracted to children and do not ever want to hurt them.” Additionally, clients may seek direct reassurance from others, as exemplified by their asking their clinicians, “How sure are you that I am not a pedophile?” In relation to response prevention for a P-OCD-related exposure, clients are instructed to refrain from engaging in these types of reassurance-seeking. It is important for clinicians to anticipate and detect reassurance-seeking when it appears, and to assist the client in refraining from seeking reassurance. This can be done by explaining to clients the symptom-reinforcing effects of such compulsions, as well as reiterating the rationale for response prevention during Ex/RP. In similar fashion, clinicians can remind clients to refrain from engaging in mental rituals (e.g., using positive, innocuous thoughts to neutralize pedophilia-themed thoughts, or engaging in mental review of past events as a form of self-reassurance that they did not commit pedophilic acts) during exposure.

Clinicians should provide guidance and support on how the client should respond when the urge to do a compulsion becomes difficult to resist. Clients are often instructed to “lean into” their anxiety by disrupting the cognitive ruminations with statements that do not contradict the obsessions. For example, when clients have the obsession, “What if I am a pedophile?” they may be instructed to address that obsession by saying, “I may be a pedophile” or “I don’t know if I’m a pedophile.” Such statements provide the client with opportunities to practice tolerating the uncertainty that accompanies pedophilia-themed obsessions. The use of these types of statements should be practiced during individual sessions so that clinicians can monitor the clients’ level of anxiety and ensure that they are being used properly, without compulsions. Other strategies used to prevent the use of compulsions include focusing on the external environment and participating in activities that shift attention away from obsessions and anxiety. For example, a client may be instructed to spend some time focusing on their surroundings (e.g., mindfulness activities) or engage in a conversation with a family member or friend about something pleasurable. Active engagement in these tools aids in preventing the ruminative process (mental compulsions) that strengthens the OCD. When used consistently, clients may experience a decrease in intensity of their obsessions and decreased pressure to perform compulsions.

Psychoeducation plays a key role in helping clients become aware of when they are performing mental compulsions, how these compulsions ultimately reinforce OCD symptoms, and how to appropriately engage in response prevention to bring about symptom improvement. Furthermore, it is helpful for clients to realize that by complying with response prevention instructions, they are also putting the maladaptive cognitive processes (e.g., overimportance of and need to control thoughts) implicated in their OCD to the test. For example, by realizing that the anxiety accompanying pedophilia-themed obsessions triggered during exposure will naturally decrease or be better tolerated over time, clients will thereby learn not to catastrophize about their unwanted thoughts, and that such thoughts will fade away even without controlling or suppressing them.

**Treatment Outcomes**

Because there is little research addressing the effectiveness of Ex/RP for P-OCD specifically, it is unclear what percentage of clients find Ex/RP a successful treatment approach at this time. As stated earlier, clients with sexual obsessions may be considered more treatment-resistant and may improve less than those with other subtypes of OCD. However, from our experience working with this population, clients who engage in treatment fully (e.g., attend sessions regularly, commit to daily exposure homework, and to response prevention) benefit greatly from treatment and enjoy a return to a level of functioning similar to...
that prior to the onset of P-OCD symptoms. For 25 clients treated at our clinic with Ex/RP for primary P-OCD concerns, the mean Y-BOCS-II Severity Scale score dropped from 31.2 (SD = 8.2) to 13.6 (SD = 6.9). Clients had a median number of 35 visits (including consultation, assessment, and treatment). Many of these clients were also treated for comorbid conditions (such as major depressive disorder) and few clients dropped out once treatment started (8%).

For example, a married father who sought treatment from our clinic was diagnosed with severe OCD. His pedophilic fears were so impairing that he was unable to change his daughter’s diapers, bathe her alone, or allow her to sit on his lap due to intrusive images and distressing worries that he may become sexually aroused by her. After several months of twice weekly sessions and daily homework, this client was able to enjoy a considerable amount of symptom reduction. Without needing supervision from his wife or asking for reassurance, he was able to care for his daughter’s daily needs in a similar fashion to other typical fathers. While his obsessions were still present on most days, he was able to resist compulsions (i.e., response prevention) and continue engaging with his daughter. His obsessions were weaker and less frequent, and he was easily able to dismiss them when they occurred. This outcome is considered ideal for P-OCD sufferers, as they must learn to accept the presence of obsessions and learn to resist compulsions to receive optimal benefit from Ex/RP.

Conclusions

Although there are effective interventions for the treatment of OCD, including behavioral, cognitive, and pharmacologic interventions, many individuals lack access to such treatments and continue to suffer. For individuals who do seek OCD treatment, those expressing taboo obsessional content, as in P-OCD, may continue to suffer. For individuals who do seek OCD treatment, interventions, many individuals lack access to such treatments and may be misunderstood and improperly attended to by mental health professionals (Glazier et al., 2013, 2015). As a result, it is imperative to increase awareness among providers in the mental health and related professions to ensure clients receive timely and appropriate care.

Clients with P-OCD who undergo Ex/RP often worry about how they will fare afterward. Despite the clear efficacy of Ex/RP, no clinician can predict the precise degree to which a client will benefit from the treatment. Clients suffering from unacceptable thoughts (e.g., P-OCD) may experience poorer Ex/RP outcomes than clients with non-taboo forms of OCD (Williams et al., 2014a); however, it is important to reiterate to the client that the goal of treatment is not to eliminate all intrusive thoughts (e.g., obsessions) but to decrease the intensity and frequency of obsessions by eliminating compulsions and learning to tolerate and habituate to anxiety. Much work still needs to be done to tailor treatment to symptom presentations in P-OCD in order to improve outcomes. Because Ex/RP principles are assumed to be consistent for all manifestations of OCD, current treatment manuals tend to be written in more general terms without providing specific examples for the unique symptoms found in P-OCD. Therefore, it is hoped that the clinicians can benefit from the information provided in this article, in ensuring that clients with P-OCD do receive an accurate assessment and correct diagnosis, as well as optimal therapy, in order to improve their treatment outcomes.

Finally, future research needs to further assess treatment outcomes for this particular clinical population, as well as examine potential modifications to Ex/RP and other modalities that may improve treatment outcomes. Assessment tools that can be used to effectively distinguish P-OCD from pedophilic disorder are also needed to assist mental health professionals less familiar with the disorder. Such measures may also help to further identify factors implicated in the development, maintenance, and treatment of such symptoms.

Acknowledgements The authors would like to thank Jessica Combs, Psy.D., and Judy Mier-Chairez, B. S., for their assistance with earlier drafts of this article, and Chandler Smith for help with data entry.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

References


