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Unwanted Erections in Obsessive–Compulsive Disorder

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The presentation of inappropriate penile erections calls for great caution in making a diagnosis. Two patients who had unwanted erections also had obsessive–compulsive disorder – a previously unreported association. Obsessive–compulsive disorder is *not* inconsistent with unwanted erections and should be considered in assessment.

Obsessive–compulsive disorder has a diverse content; it is estimated that 5–9% of obsessional patients experience intrusions of a sexual nature (Aktar *et al*, 1975; Stern & Cobb, 1978). Such obsessions are often particularly repugnant and distressing to patients, who may find it hard to admit to their worries (Salkovskis & Kirk, 1989).

In a further group of obsessional patients, sexual activity may be avoided as a consequence of intrusive thoughts about contamination. Behavioural treatments are successful in up to 85% of obsessive–compulsives (Foa & Goldstein, 1978), and there is no data to suggest that patients troubled by sexual obsessions respond any differently.

Although there is evidence that anxiety can facilitate sexual arousal (Bancroft, 1974; Barlow *et al*, 1983), the occurrence of unwanted erections in obsessive–compulsive disorder has not previously been recognised. There are considerable difficulties in diagnosis and management of such presentations, particularly in the absence of previous reports. These difficulties can only be clarified by a careful examination of the clinical features and psychological processes involved in each case. We report two cases of obsessive–compulsive disorder where unwanted erections were described in association with obsessional phenomena to the great distress of the patients. To our knowledge, this is the first published report of this phenomenon.

Case one

A 43-year-old married man with an 18-month-old daughter had been successfully treated for obsessive–compulsive disorder using cognitive-behaviour therapy. He experienced a wide range of intrusive thoughts and imagery, associated with extensive overt and covert neutralisation. The central theme was always that he might be responsible for harm befalling his wife and child and had to try to prevent this by ritualising. Towards the end of this treatment he admitted for the first time that he was frequently experiencing erections when he was with his daughter. Erection could occur immediately before, immediately after or simultaneously with anxiety-provoking intrusive thoughts and images of a sexual nature. Erections, intrusive thoughts and images were perceived as alarming, repugnant and unwanted and were strongly resisted. He neutralised these intrusions by producing 'good' thoughts and images and began to avoid the child as much as possible. When he had to be alone with the child, he immediately tried to suppress erection and thoughts. He interpreted the combination of intrusive thoughts and erections in a particularly negative way; for example: "This must mean I am a pervert", "This means I might assault my daughter". Unlike his other obsessions, he was unable to confide in his wife, and he became increasingly depressed with occasional suicidal thoughts. He had at *no time* had, and had *no* desire to have, sexual contact with the child.

Once the diagnosis had been clearly established, then treatment was instigated. Initially, this involved instructions to stop avoiding his child, a programme of graded exposure and instructions in response prevention (focused on his covert neutralising; see Salkovskis & Warwick, 1988). Although he had previously used exposure and response prevention successfully, he felt unable to comply because of extreme anxiety levels. Careful enquiry revealed that he felt that the occurrence of unwanted erections made this 'different' from his other obsessions and was afraid that the feared consequence might occur.

Assessment revealed that he believed that he should always be able to control and prevent unwanted erections; his failure to do so made him think that he might be a pervert. Patient and therapist then discussed an alternative explanation which could be readily applied to his problem. Blushing was used as an example of a common autonomic response which cannot always be controlled and which occurs in situations associated with anxiety. Furthermore, blushing tends to occur paradoxically when suppression is attempted. The common role of blood flow changes was a further parallel. After this discussion, the unwanted erections virtually disappeared and the patient resumed normal contact with his child without ritualising. Twelve months later he remained symptom free.

Case two

The patient was a 38-year-old polytechnic student. He presented at the emergency department of the general hospital, complaining of 'evil thoughts' and requesting psychiatric admission. Four years previously, he had been admitted to a psychiatric hospital with depression and

intrusive thoughts; he made several suicidal attempts at this point. He had previously been diagnosed erroneously as schizophrenic, apparently on the basis of his obsessional thoughts and a six-hour psychotic episode precipitated by amphetamines. Although it was evident that he had been troubled by intrusive thoughts for several years, the present episode had begun three days previously when a colleague was visited by someone with children. The patient had thoughts concerning sexual and violent assault, and had become increasingly anxious about the possibility that he might act on these.

When he was first seen, he was extremely reluctant to describe his thoughts, and the details emerged over the course of several sessions. Previous thoughts had concerned sexual and violent acts towards women. During the episode leading to presentation, the thoughts centred on violent sexual assault of children, although within two weeks this had extended to women and to men. He found these thoughts extremely repugnant and said that he definitely did not want them. He was quite clear that the intrusions were the product of his own mind, but found this fact to be very alarming. His reaction was to try to suppress the thoughts, to avoid situations where he might encounter children and to repeat stereotyped phrases to himself when the thoughts occurred, such as "I won't do it"; "It's prison for me". He constantly sought reassurance about how likely it was that he might act on his thoughts. He would verbally check whether he might have accidentally assaulted someone. During therapy sessions he would talk very quietly and frequently check that he could not be overheard. A major factor in his fears was the fact that his brother had, four years previously, been convicted of assaulting two women. The patient had interpreted his own intrusive thoughts as a sign that he might act in the same way.

Two months after his first attendance, he described two different types of circumstances where erections were associated with his obsessional thoughts. Firstly, he would experience intrusive images (always concerning children) when he masturbated to photographs of adult women. Initially, he had tried to suppress these images; when they continued to occur, he tried to desist from masturbation altogether. He was concerned that the occurrence of intrusions at this time indicated a possible subsequent loss of control and 'acting out'. Secondly, he noticed that he had an erection on at least two separate occasions when intrusive thoughts and images of violence to children occurred in the context of standing near children during a treatment programme. He found this second experience particularly alarming, because it seemed to him to be a sign that he was on the verge of losing control and attacking the children he was near. He reported that this fear was based on the thought "I have already kind of lost control; my body is out of control". In both instances, he found the erections extremely repugnant. Treatment was prematurely terminated as the consequence of a major life event which resulted in the patient moving to another part of the country.

Discussion

It is vital to establish the diagnosis where penile erection is reported in association with unusual stimuli. In these cases, the erections and the associated intrusive thoughts and images were regarded as repugnant and senseless. They were strongly resisted and were associated with avoidance and overt and covert ritualising. There was no urge to have sexual contact with children and the patients continued to have normal sexual fantasies and/or relationships. There was no history of paedophilia and sexual fantasies involved only adult women. The first patient's obsessions had previously concerned topical issues (e.g. hepatitis B and AIDS), and the unwanted erections coincided with publicity about child abuse. In the second patient, his brother's previous conviction for assault played an important role in his concerns. These factors confirmed the diagnosis of obsessive–compulsive disorder, and paedophilia was excluded.

This phenomenon could be an example of discordance between autonomic sensations and demonstrable autonomic changes. However, both cases *said* that their erection was palpable and it was visible to the one patient in whom circumstances allowed inspection. While this report would have benefited from objective measurement of erections, this was considered unjustifiable in these clinical cases, who were not involved in a research study. Both were alarmed by the experience and perceived implications of unwanted erections, and objective measurement would have clearly added to their distress, without any clinical benefit. Future studies of this phenomenon might attempt such measures, before and after treatment. In these cases, the perception of erection was the source of alarm. Conclusions here necessarily concern *perceived* sexual arousal, although this correlates well with actual changes in penile circumference (Bancroft, 1974).

Erections were associated with obsessional intrusions in two ways: (a) obsessional intrusions occurring during usual sexual activity; and (b) intrusions directly associated with erections. In the former unwanted intrusive thoughts and images occur during sexual arousal *unrelated* to the intrusions. Thus, case two reported that masturbation to his usual heterosexual stimuli was interrupted by obsessional intrusions. Attempts to suppress intrusions tended to increase their frequency and led the patient to refrain from masturbation. Barlow (1986) reports that sexual dysfunction is often associated with distraction by irrelevant (non-erotic) stimuli and a paradoxical effect has been shown to operate when attempts are made to suppress intrusive stimuli (Salkovskis, 1989). These phenomena may account for the impairment of sexual relationships in some obsessional patients.

Given the conventional view that sexual arousal and anxiety are incompatible, the association between erections and obsessional intrusions which provoke anxiety is unexpected. However, there is evidence that the relationship between sexual arousal and anxiety is more complex. In studies on aversion therapy in homosexuals, Bancroft (1974, p. 126) observed that *increased* sexual arousal sometimes followed aversive (shock) stimuli, possibly because of contrast effects. More recently, Barlow *et al* (1983) reported that, in men with no history of sexual dysfunction, anxiety related to the threat of shock *enhanced* sexual arousal as indexed by penile plethsymography. This effect was slightly increased if the shock was perceived by the subjects as being contingent upon the subjects' erectile response, i.e. if the erectile response were itself the focus of anxiety. These data suggest that, for obsessionals in whom there is some association between sexual stimuli and anxiety-provoking thoughts, the occurrence of sexual arousal is a not unlikely consequence. If a patient with an obsessional disorder reports associated erections, the diagnosis of obsessive–compulsive disorder is not automatically called into doubt.

When apparently inappropriate sexual arousal is detected in the context of an obsessional problem, it is important that a diagnosis is reached on the basis of the phenomenology of the problem as a whole rather than the occurrence of isolated symptoms. It is obviously vital that sexual deviation is accurately excluded. The association of obsessional thoughts and sexual arousal may occur relatively frequently, but seldom be revealed because of associated guilt and fear of the consequences of disclosure. An inexperienced therapist who is unaware of the possibility of an association between obsessional problems and sexual arousal may fail to implement proper behavioural treatment because of doubts about the nature of the phenomenon, and perhaps also communicate these doubts to the patient. Treatment of obsessive–compulsive disorder involves the explanation that the occurrence of obsessions represents the intrusion of unwanted and senseless thoughts into consciousness. Acceptance of this view is important for compliance with behavioural treatment (Marks, 1987), but both our patients found the occurrence of erections an obstacle to their acceptance of the treatment rationale. Patients have found the following explanation particularly helpful and easy to understand: "Erections are a reflexive response involving changes in blood flow, and can be regarded as similar to excessive blushing in social situations. As often happens with blushing, the more anxious one becomes about the response itself, the more likely it is to happen, because the reflex can be paradoxically set off by anxiety." Careful explanation about the nature of unwanted erections is crucial – without this appropriate behavioural treatment may be unacceptable to these patients.

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