Psychotherapeutic Management of Sexual Obsessions in Childhood: A Case Report

To the Editor,

Obsessive compulsive disorder (OCD) is a psychiatric condition that can lead to significant impairment in various areas of one’s life and can affect the developmental process. The lifetime prevalence of OCD in adolescence is found to be 1.9 ± 0.7%. Early onset OCD is characterized by multiple obsessions and compulsions. There is limited literature on childhood OCD characterized by pure sexual obsessions. Childhood OCD is often chronic, is characterized by relapses and remissions, and has implications for long-term management. Children with sexual obsessions report disgust, embarrassment, shame, and intense anxiety with these thoughts. Cognitive behavioral therapy (CBT) has been considered as the most effective treatment for OCD in children and adolescents, and the chances of recovery are good in case of sexual obsessions in children as they respond to standard strategies of treatment.

A 10-year-old boy studying in the 6th grade was brought to the Psychiatry Outpatient Department with complaints of distressing palpitations and crying spells. Upon exploration, these symptoms were found to be accompanied by thoughts that were sexual in nature and would occur repeatedly in his mind for the last 2 months. He was having repetitive thoughts of engaging in inappropriate sexual activity with his mother, teachers, or other females. He had fear that he might inappropriate
hug or kiss his mother or teacher. He used to try to distract himself but was unable to do so even with great effort. He used to feel disgusted and guilty after having these thoughts. These thoughts would occur at any time and irrespective of any activities he was engaging in. He had these thoughts in school, and they interfered with his academic performance as he was finding difficult to concentrate. He recognized them as his own thoughts, and in response to these thoughts, he would sometimes engage in neutralizing behavior such as thinking about some pleasant memories, to get rid of these thoughts.

He was diagnosed with F42.0 OCD-Predominantly obsessional symptoms and started on escitalopram 10 mg and clonazepam 0.25 mg. CBT was initiated. Ten weekly sessions were held with the focus on assessment, psychoeducation, building cognitive resistance and constructive self-talk, and alleviating anxiety and preparing for relapses.

A detailed history was taken along with a baseline assessment on Children’s Yale- Brown Obsessive Compulsive Scale (CY-BOCS) on which 13 was the total score (11 on the five-item obsessions scale and two on the compulsions scale), indicative of mild severity of the symptoms.

The first two sessions were focused on psychoeducation, in which information was provided to the parents and the client regarding the etiology of OCD, including the neurobiological and psychosocial mechanisms along with a clarification of any misunderstandings related to the disorder. The major goals and components of CBT were communicated.

The aim of the next six sessions was to enable him to externalize OCD, to build his self-confidence, to deal with anxiety and fears, and to reward himself. He was asked to rename these thoughts. He renamed OCD as “villain,” and it helped him in relieving himself of the shame and guilt he was experiencing as a result of these thoughts. When he started externalizing the thoughts, the previous level of distress started declining. He learnt that these thoughts were because of the disorder, and he was not responsible for them. The technique of “fear thermometer” was used, in which he used to rate the anxiety-provoking situations. He was taught “riding the worry hill technique,” in which it was explained that dealing with fears is like riding up and down the worry hill, and he is the one who controlled the bicycle. This technique enabled him to build self-confidence and made him in charge of the situation. It was ensured that he independently dealt with his anxiety and fears, and it was conveyed to the parents by the therapist that their role was not to reassure him while he was experiencing anxiety. When he was able to deal with his anxiety independently, he was rewarded by the parents and the therapist in the form of praise and reinforcers that were planned according to his preferences. Parents were trained in differential attention. Whenever he used positive coping and did not engage in OCD related behaviors, he was reinforced by them. After the sixth session, CY-BOCS was repeated, and the score was 6, indicative of subclinical severity of obsessions. After the eighth session, CY-BOCS score was 3.

The last two sessions emphasized relapse prevention. The patient and his parents were psychoeducated regarding the possibility of relapses. The importance of having realistic expectations, identifying the relapse signs, and seeking immediate intervention was elaborated upon. A booster session was taken after 6 weeks to assess the changes. The CY-BOCS score remained 3. His academic grades improved. After 2 months, a follow-up session was taken, and the CY-BOCS score was 2, which fell in the subclinical range. Subjectively, he reported no distress, and he was managing well in his personal, social, and academic spheres.

The above case is being reported for its unique presentation and to highlight the effectiveness of CBT as a successful treatment modality along with pharmacotherapy for OCD in children. Children with OCD often have poor insight. They are less likely to understand the significance of treatment without assistance from their parents and also require substantial structure and more supervision from the therapist as well as parents to participate effectively in CBT.

Certain challenges were faced while managing the case. One was related to eliciting the symptoms. The child did not describe the symptoms in the first interview. However, when rapport was established, he comfortably talked about his symptoms. Rapport was built using a number of techniques in the form of making the child feel comfortable by not asking too many questions, by praising him, and by engaging him in one of his favorite activities, i.e., sketching. Because it was difficult to make the child understand the symptoms adequately, pictures and graphs were used to explain the symptoms and the techniques to deal with them. For instance, when the child was assigned homework to rate his fear and emotions associated with the symptoms, use of emoticons was made. There were no other significant challenges faced in relation to engaging the child in the therapeutic process. In this case, there was no family history of psychiatric illness, and it was difficult for the parents to understand his symptoms. The treatment thus required the involvement of the parents and the necessity to psychoeducate them regarding the illness. Because of the symptoms, there was a significant decline in his academic performance, which was also causing a
lot of distress to the patient and his parents. Therefore, the treatment focused on assessing the dysfunctions in various domains, including academics and social life, to develop strategies specific to work with these areas of difficulties. In this case, once the obsessional symptoms were dealt with, the academic performance of the child started improving. Some strategies that might be useful in improving the academic performance include a structured study schedule, time management, setting small and achievable targets, elaborative rehearsal, and use of principles of reinforcement. In some cases, if the child has difficulties in the social relationships as a result of feelings of inferiority or embarrassment because of his/her symptoms, effective social skill training methods might be useful.[8] In this case, there were certain protective factors, including good family support and cognitive sophistication in the adolescent, which made it easier for him to understand and apply the cognitive strategies effectively. The cognitive functions, especially executive functions, are one of the factors to be suggested as a good predictor for treatment response.[9]

Future work should focus on developing cognitive strategies that are specific to Indian children in intervening with sexual obsessions, to make it more culturally specific, as there might be some cross-cultural variations in the course of illness and the clinical characteristics might also differ.[10]

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**

There are no conflicts of interest.

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