Missing Pedophile OCD:
Don't Let This Happen to You

By
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Don't let what *happen to me? Did I read this right*? Now that my title has grabbed your attention, I hope you will allow me to explain: By "you" I am referring to you, the therapist; by "this" I am referring to a potential misdiagnosis; and by "Pedophile OCD" I am referring to a form of Obsessive-Compulsive Disorder that is one of the worst types there is. With POCD, the person is worried that they *might* be a pedophile. But they aren't.

This is perhaps your potential new client – someone who was finally brave enough to make it through your door and share their most unspeakable fear – that they might be a sexual predator of children. In actuality, this is a harmless human being who was beseeched by a "what if" thought that entered their mind at the most inopportune moment. Perhaps they heard the word "pedophile" in the news or watched an evil predator on TV. They might have had a random image of a child flash through their mind right when they were in the middle of making love. Or, at another ill-timed moment, they saw a photo of a child next to someone's bed, or heard the voice of a child playing outside – right at the moment of orgasm.

In that split second, these paired associations partnered together "Pavlovian style" and did a hostile takeover on somebody's brain. And now that person fears they are somebody evil. From that day forward, "What if I'm a pedophile?" is a thought that never stops running through their mind. Combining the scariest form of "Harm OCD" with the worst of "Sexual Orientation OCD," POCD is a shameful, isolating experience. As they come to you for help, you are likely to ask your own set of questions: "Is this about sexual attraction? Is it Pedophilic Disorder? Is the client a danger to others?"

These are questions that previous therapists also had. Many of them took the clients' words *prima facie*, leaving them feeling *more* worried and shameful. According to my clients, psychodynamic therapy came at great financial cost and over many long years, but exploratory work did nothing to ease their pain. Aversion therapy encouraged techniques like snapping their wrists or making themselves sick, an ineffective and demoralizing process. Old school CBT therapists, not current with the research on "thought suppression," unsuccessfully recommended "thought-stopping." Psychoanalytically trained therapists urged them to talk about repressed sexual urges, creating an inference of plausibility. Trauma-based therapists conveyed the possibility of a past molestation, an event that never occurred. Some therapists produced needless fear by mentioning that this might be "reportable." Specialists in paraphilic (sexual) disorders often took the lead, leaving clients feeling even more deviant and defective than before.

"Well," you might be thinking, "what if *this* OCD specialist is also looking through *her* narrow lens, and overlooked the fact that this really is a pedophile?" To answer this very valid question, Pedophilic Disorder can and should be ruled out, and if there is no desire to view child pornography, that is a very strong clue. There is also almost always some history of OCD in the person's past, even if it used to be counting or checking, and often there is a family member who also suffers from OCD. But the real litmus test is how the client *feels* about their intrusive thoughts. If they're breaking down in your office, and saying their thoughts are disturbing, it's ego-dystonic. It's *their* worst nightmare, not someone else's.

None of us ever wants to confuse a diagnosis or offer the wrong treatment, but missing ***this*** diagnosis, when it applies, has the potential to forever desecrate a client's life. This is a diagnosis we have to try never to get wrong. Imagine, for a moment, just how many other lives would be impacted if someone with POCD (or their therapist) never knew just what it was. These are clients who make false confessions, or isolate themselves for the purpose of "protecting" children. Imagine . . .

A woman ends a relationship with her dearest friend who opens a daycare center.
A nurturing mother no longer touches her baby.
A wedding is called off after the couple decides to share <u>all</u> of their innermost thoughts.
A gifted fifth grade teacher abruptly ends his career.
A loving husband and would-be father reneges on his promise to start a family.

In my article, ***Searching for Bad News: The Circuitous Path of Obsessive Thinking,*** I describe how people with obsessive types of OCD use a form of internal hypervigilance; checking their minds to see if certain thoughts have gone away, checking their body to see if they feel aroused when thinking about a child, or checking their character to see if they feel like a bad person inside. None of that is possible, by the way. As we learned from Daniel Wegner's "White Bears" experiment, we have to conjure up a thought in order to reject it, and once that happens things get sticky from there. Clients who focus on their genitals don't truly get an answer about whether they feel anything. Many males report feeling a vague uneasiness in their groin area, and because they feel "something," they worry it is evidence of sexual arousal. Checking their character involves trying on different scenarios to investigate what their reactions "might" be, but in this dissociated game of speculation, they can't really be sure. (Was that a surge of repulsion or excitement? It's hard to tell).

Whether they feel something or they feel nothing, checking rituals become self-reinforcing. Behavioral compulsions, if there are any, might include checking the news to see if they were identified as a criminal, or checking children's faces to see if they look frightened or uneasy in their presence. But children may wince or turn away for a variety of reasons, including the discomfort of being stared at. Sadly, POCD clients are likely to dismiss such reasonable explanations, making up their own "evidence" to vilify themselves.

When clients ask the question, "What if I'm a pedophile?" I tell them they're not asking the right question. The question they should be asking is, "Do I have OCD?" Rather than researching the characteristics of predators on-line and running a side-by-side comparison (an ill-advised "checking" compulsion), we look at the diagnostic criteria of OCD.

If the first goal of therapy is psychoeducation, another important aim is to convey the futility of checking. When I hear clients insist on "knowing" who or what they are, I do various experiential exercises to demonstrate that "***some things are impossible to check.***" These clients are not just pondering, "What if I'm a child molester?" they are really wondering, "What if I'm a child molester ***and I don't know about it****?"*

This subtle distinction is actually a blatant diagnostic clue. ***"It might be real even though I don't know about it"*** is a nothingness, a void, an empty space that ***cannot be examined because nothing is there****.* Even though it is an amorphous idea that cannot be explored, OCD clients are determined to unravel this type of paradox. To them, a lack of verification seems like a guilty "yes" when it is really a sincere "no." Different images, different thoughts, different situations, different states of arousal – all need to be investigated and exhausted until the "there is nothing" answer remains. As one client explained, "You want to be 100% certain that something isn't true. So you search really, really hard to make certain. But in the process, you get so attached to the idea that you start to believe it."

Exposure-based treatment in CBT isn't about watching child pornography or encouraging inappropriate interactions with children. Rather, the work is to achieve habituation. Clients may be encouraged to write or say triggering words, look at their niece or nephew's picture, listen to children's voices, or show up at events where children are present. Moving up the "hierarchical scale," we work with an imaginal exposure that the client writes, records, and listens to in their own voice. The script contains their worst scenario: being accused and convicted of child molestation, devastating their loved ones who ultimately disown them, losing their sense of who they once were, and watching their lives come crashing down. Having no more threats left in its arsenal, OCD relents. Treatment is surprisingly quick (weeks to months), and, when introduced in the right way, remarkably effective.

So, now that you recognize this disorder:

A friendship endures through a lifetime of seminal moments.
A child sleeps in her mother's arms.
A couple's wedding vows express wholehearted trust.
A teacher touches the lives of two generations of children.
A husband strokes his pregnant wife's belly.

All because you didn't miss Pedophile OCD.