



Co-Occurring Obsessive-Compulsive Disorder and Sexual Dysfunction

Contributors: Amy E. Wright

Obsessive compulsive disorder (OCD) is a neuropsychiatric disorder characterized by distressing obsessive thoughts and mental or physical compulsions performed to temporarily reduce this distress (Singh et al., 2023). OCD is a leading cause of psychiatric morbidity with a worldwide prevalence of 1-3% and is comorbid with many psychiatric and medical conditions (Brock et al., 2024). OCD is associated with reduced quality of life as well as its frequent comorbidities, including sexual dysfunction. However, the research and clinical guidance in this area remain limited, in part due to the difficulty of studying OCD and its overlap with other issues that may contribute to sexual dysfunction.

Sexual dysfunction commonly co-occurs with OCD. Ghassemzadeh et al. (2017) reported that 80.6% of female-identified people with OCD and 25% of male-identified people with OCD also reported sexual dysfunction. The relationship between OCD and sexual dysfunction is complex and bidirectional, such that symptoms of one impact the progression and presentation of the other. However, researchers have not reached a consensus about what, if any, factors modify this relationship. Ghassemzadeh et al. (2017) reported that participants with OCD but without depression experienced greater erectile dysfunction, lower sexual satisfaction, and more pain during sexual activity than participants with OCD and depression.

OCD is commonly misdiagnosed, in part because clients may first report obsessions unfamiliar to their clinician (Weinberg et al., 2025). Given the high rates of co-occurrence of OCD and sexual dysfunction, the presentation of sexual dysfunction may serve as an opportunity to also assess for OCD. Early diagnosis and appropriate treatment of both conditions could improve clinical outcomes as well as reduce stigma. This may especially benefit people with marginalized identities given the growing evidence that exposure to discrimination is associated with increased OCD symptom severity (Williams et al., 2020).

Sexual dysfunction can co-occur with any subtype of OCD but appears to be particularly evident for people with relationship OCD (ROCD). ROCD involves recurrent doubts about a relationship or partner (Doron et al., 2014a). Though doubt and worry are normative in romantic relationships, people with ROCD become so preoccupied with these doubts and the associated compulsions that their functioning is disrupted (Derby et al., 2024). Doron et al. (2014b) found that ROCD symptoms were associated with decreased sexual satisfaction regardless of factors such as worry, depression, OCD and attachment style.

Often called the “doubting disorder,” OCD leads people to doubt their own memories and self, instead seeking reassurance through compulsions (Chiang & Purdon, 2023). To address pervasive doubts, people with OCD often seek “objective” evidence to reduce uncertainty. For example, someone with contamination OCD might rely on mold tests to reduce their worry about breathing in pathogens. In ROCD, this type of compulsion often manifests as excessive monitoring of internal states or more objective measures (Lazarov et al., 2015). For example, a person with ROCD may have the thought “What if I am not attracted to my partner?” They might then seek reassurance by assessing their arousal during sex (e.g., asking themselves “Am I aroused now? How about now?”) or more objectively (e.g., monitoring the firmness of their erection). One emerging hypothesis about the relationship between rOCD and sexual dysfunction is that alleviating doubts by continuously monitoring arousal may paradoxically reduce

arousal because it diverts attention away from the present sexual act and toward non-erotic cues (Doron et al., 2014b).

Assessment Strategies

Assessing OCD symptom severity and OCD symptoms within romantic relationships in tandem may address the limited understanding of factors that contribute to OCD comorbidity with sexual dysfunction. Two assessments may be particularly helpful toward this aim: the Yale-Brown Obsessive-Compulsive Scale—Second Edition (Y-BOCS-II) and the Relationship Obsessive-Compulsive Inventory (ROCI).

The Y-BOCS-II is a clinician-administered and clinician-rated measure of OCD symptom severity in adults. The assessment includes two parts: a symptom checklist and a ten-item severity scale rated from 0 (no symptoms) to 4 (severe symptoms; Storch et al., 2010). It has high validity and reliability and is considered the “gold standard” in the assessment of OCD symptom severity (Benito & Storch, 2011; Castro-Rodrigues, 2018; Storch et al., 2010). The Y-BOCS-II should be administered as part of a comprehensive assessment integrating cultural assessments, collateral reports, the client’s self-reports, and the clinician’s judgment.

The ROCI is a self-reported assessment of obsessions and compulsions related to a person’s romantic relationships. The instrument assesses three relational dimensions: perception of the partner’s feelings; perception of own feelings toward the partner; and the perception of the “rightness” of the relationship with the partner. It consists of 12 items, each rated on a 0-5 scale, and assesses how closely the respondent’s experiences align with symptoms of ROCD (Doron et al., 2012). The ROCI has not been studied across diverse populations, so clinicians who choose to administer it should consider how their client’s intersecting identities impact the utility and interpretation of this assessment.

Although sexual dysfunction is often rooted in mental health challenges and responds well to counseling, it can also have underlying medical causes. Physical causes of sexual dysfunction include multiple sclerosis, vascular disease, diabetic neuropathy, and menopause (Kershaw & Jha, 2022; Roostayi & Rahdar, 2022). People experiencing sexual dysfunction should consult a physician to determine if medical treatment is required. A primary care physician may refer a client to specialist services such as obstetrics and gynecology, endocrinology, neurology, and cardiology. Physical therapy—particularly pelvic floor physical therapy—may also benefit people of all genders experiencing sexual dysfunction (Quaghebeur et al., 2021).

Scope of Practice

Diagnosing and treating both OCD and sexual dysfunction is unambiguously within counselors’ scope of practice. However, clinicians should consider additional training or referral if deemed necessary to protect the client from harm.

Treatment Approaches

Exposure and response prevention (ERP) is widely considered the first-line treatment for OCD. People with OCD develop compulsions to attenuate the distress caused by obsessions, but the avoidance afforded by the compulsions prevents the person from experiencing and habituating to the distress caused by the stimulus. This ultimately leads to the heightening of both obsessions and compulsions. ERP, a type of cognitive behavior therapy (CBT), interrupts the cycle of escalating obsessions and compulsions. By creating opportunities for exposure to distressing stimuli without engaging in compulsions, ERP increases the client’s distress tolerance and self-efficacy (Xu et al., 2024). ERP is an effective OCD treatment irrespective of subtype or obsessive content, including ROCD (Hezel & Simpson, 2019).

CBT is a well-studied and effective approach for sexual dysfunction counseling (Metz et al., 2017; Mirzaee et al., 2020). In this context CBT may include cognitive restructuring, psychoeducation, relaxation training, and directed masturbation (Stephenson & Kerth, 2017). Research also supports the utility of additional counseling modalities in addressing sexual dysfunction. Approaches include: mindfulness-based therapies (Stephenson & Kerth, 2017), narrative therapy (Fallah & Ghodsi, 2022), and acceptance and commitment therapy (Mohagheghian et al., 2021). Although ERP and CBT are empirically supported interventions, the specific population of people with ROCD and sexual dysfunction may require additional considerations and adaptations.

While ROCD and sexual dysfunction can be treated independently, they are interrelated in those who experience both simultaneously. Counseling should attend to both issues as well as their intersection. For example, a clinician using a CBT approach to address sexual dysfunction in this context must be mindful of the ways OCD pathology may undermine specific CBT interventions. While challenging unhelpful thoughts is an important component of CBT, the process of gathering evidence for and against a thought can feed into an OCD certainty-seeking behavior (Williams et al., 2022). It is imperative that clinicians using these techniques with this population remain vigilant in assessing OCD symptoms and are willing and able to return to ERP as needed.

Clinicians should also consider the relationship between OCD and trauma when determining the course of treatment. OCD and trauma-related disorders have significant overlap, and OCD often develops as a type of maladaptive coping mechanism in response to traumatic experiences (Wadsworth et al., 2023). As a person with OCD begins treatment, they may experience increased instability due to the loss of an established and effective coping strategy. Clinicians should be prepared to address a potential influx of trauma-related symptoms, including helping the client develop healthy coping skills and access sources of support. If a client has co-occurring PTSD or has been exposed to a discrete trauma that will interfere with ERP progression, clinicians should consider treating the trauma symptoms concurrently or before initiating ERP to prevent retraumatizing the client (Pinciotti et al., 2022).

Cultural and Ethical Considerations

Clinicians should exercise cultural humility as they assess and address how a client's identities and culture of origin impact their experiences and clinical presentation of OCD and sexual dysfunction. For example, Williams et al. (2021) found that African American individuals with OCD reported elevated contamination obsessions and compulsions compared to non-Hispanic White individuals with OCD and suggested this may be due to stereotype threat around cleanliness. This same pattern may contribute to a hesitation from African American people with OCD to disclose sexual obsessions due to malignant stereotypes about sexual deviance and violence (Williams et al., 2017).

Factors such as gender identity, sexual identity, ability, and racial and ethnic identities shape the approach, goals, and course of counseling. Clinicians using ERP and CBT should consider modifying language, metaphors, and exposure stimuli to ensure clients receive culturally responsive care that does not promote harmful stereotypes. CBT adaptations may include approaches such as LGBTQIA+-affirmative CBT (Faubion & Rullo, 2015; Pachankis et al., 2022). A culturally conscious approach to ERP collaboratively designs exposures that provide opportunity for approach without forcing the client to engage in activities that violate their cultural values (Williams et al., 2020).

Clinicians treating co-occurring OCD and sexual dysfunction should ensure competency in both domains. To treat sexual dysfunction, clinicians should have a foundational understanding of human sexuality and the dimensions and contributing factors of sexual dysfunction, and should be comfortable addressing how trauma and intersecting identities impact the client's sexual expression and identity (Zeglin et al., 2018). Clinicians treating OCD should be educated about core features of OCD, subtypes and their presentations, and how cultural background shapes presentation (Williams et al., 2020). They should be comfortable assessing and diagnosing OCD and should be trained in ERP. They should receive supervision or consult with experts to ensure fidelity to the ERP protocol.

ERP has one of the largest research-to-practice gaps of any evidence-based treatment (Racz et al., 2024). One frequently overlooked barrier to implementation is the clinician's own emotional regulation (Becker-Haimes & Sanchez, 2024). ERP intentionally provokes discomfort in the person with OCD, and, in doing, so may also cause distress for the clinician. In response, some clinicians choose to reduce the intensity of an exposure or halt ERP entirely, which undermines both the client's and clinician's ability to cope with distressing stimuli (Becker-Haimes & Sanchez, 2024). It may also reinforce stigma and shame, reducing the client's willingness to continue or seek further treatment. Clinicians should be mindful of their own avoidance—of both ERP exposures and of sexual dysfunction content more broadly—and seek consultation or refer their client to a specialist if necessary.

Advocacy

Symptoms of OCD can be challenging to recognize and diagnose, especially for clinicians early in their career or those who work in a generalist capacity. Ziegler et al. (2021) found that the mean duration between age at symptom onset and age at diagnosis was 12.78 years. During this interlude, people with OCD experience significant distress, reduced quality of life, higher rates of comorbidities, and significant disruptions to their development. This is especially true for individuals dealing with both OCD and sexual dysfunction or OCD focused on taboo subjects, including sexual acts.

Both OCD and sexual dysfunction are highly stigmatized and help-seeking behaviors for both are impacted by cultural and religious beliefs. Some beliefs that may prevent a person from seeking treatment include fear of being rejected by their community, fear of confirming false stereotypes, mistrust of the healthcare system due to systemic discrimination and marginalization, and the idea that utilizing mental health care indicates weakness (Williams et al., 2020). Different communities may also have alternative understandings and explanations for a person's symptoms, preventing them from recognizing a need for help in the first place. Clinicians should engage in outreach and education to improve access to treatment for communities that may hold more of these beliefs (Williams et al., 2020). Clinicians should also discuss relevant barriers and supports with each individual client, and help the client navigate the treatment landscape to ensure proper care.

Perez et al. (2022) found that mental healthcare providers misdiagnosed OCD symptoms at a rate of more than 50%, with misdiagnosis rates for sexual-related obsessions at 52.7% compared to contamination obsessions at 11%. Though people with OCD and sexual dysfunction may not explicitly experience taboo sexual-related obsessions, it is likely that many do, and we know that many also experience symptoms of ROCD. Given OCD's high mortality rate and significant impact on well-being, it is crucial for clinicians to understand how to assess and treat those with OCD (Perez et al., 2022). Furthermore, people experiencing both OCD and sexual dysfunction may require additional and creative counseling to address both issues without treatment for one disorder aggravating the other disorder. Given the bidirectional relationship between the two disorders, addressing even one may help alleviate symptoms of the other if approached thoughtfully.

Clients will benefit from accessibility considerations (e.g., telehealth) as well as increased attention to these topics in research, clinical, and educational settings. Future research should involve active recruitment of people with marginalized identities to improve our understanding of how context impacts a client's experience with OCD and sexual dysfunction and how to best serve those populations (Pinciotti et al., 2024; Williams et al., 2015).

Conclusion

The relationship between OCD and sexual dysfunction is complex and highly context dependent. Counselors can diagnose and treat people with co-occurring OCD and sexual dysfunction but they should be mindful of the limitations of their expertise and seek additional training and consultation as needed. Though evidenced-based approaches such as ERP and CBT are considered the first line of care for people with OCD and sexual dysfunction, it is important to tailor the approach to the individual client

and their unique context. A holistic and culturally competent approach will likely incorporate collaboration with other mental health and medical professionals, as well as the client themselves and their community.

Resources

- American Association of Sexuality Educators, Counselors, and Therapists: <https://www.aasect.org/>
- Intensive Workshop in Exposure and Response Prevention for Obsessive-Compulsive Disorder: <https://www.med.upenn.edu/ctsa/workshops OCD.html>
- International Obsessive-Compulsive Disorder Foundation: <https://iocdf.org>
- NOCD: <https://www.treatmyocd.com>
- The Menopause Society: <https://www.menopause.org>
- The American College of Obstetricians and Gynecologists: <https://www.acog.org>
- Planned Parenthood: <https://www.plannedparenthood.org>
- Society for Sex Therapy and Research: <http://www.sstarnet.org>

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To Cite This Practice Brief:

- Wright, A. E. (2025, August). *Co-occurring obsessive-compulsive disorder and sexual dysfunction* [Practice Brief]. Counseling Nexus <https://doi.org/10.63134/OKUQ4534>