Assessment and Treatment of Sexual Orientation Obsessions in Obsessive–Compulsive Disorder

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Abstract

Sexual orientation obsessions in OCD (SO-OCD) are common but under-recognised and frequently misdiagnosed. SO-OCD may include worries of experiencing an unwanted change in sexual orientation, fears that others may perceive one as a member of the lesbian, gay, bisexual, transgendersed (LGBT) community, or fear that one has hidden same sex desires. The phenomenology of SO-OCD is described and contrasted with internalised homophobia/heterosexism. Examples of SO-OCD and related obsessions and compulsions are provided. Cognitive behavioural treatment of SO-OCD with exposure and ritual/response prevention (Ex/RP) is described using psycho-education, in vivo exposure, imaginal exposure, and ritual/response prevention, along with mindfulness/acceptance approaches. Due to the extreme distress caused by sexual orientation symptoms, it is important that clinicians properly identify and treat this manifestation of OCD.

Obsessive–compulsive disorder (OCD) is estimated to occur in approximately 2% of the general population (Kessler et al., 2005; Ruscio, Stein, Chu, & Kessler, 2010), and generally includes both obsessions and compulsions, resulting in significant distress and interference with daily activities. OCD is highly heterogeneous, as both obsessions and compulsions come in many different forms; therefore, each individual’s symptom presentation may be different (Williams, Mugno, Franklin, & Faber, 2013).

Sexual Orientation Themed Obsessions

Much research has been conducted on primary symptom presentations that involve checking and contamination concerns (Ball, Baer, & Otto, 1996); however, obsessions surrounding sexual thoughts have received little attention. Approximately 10.5% of those seeking treatment for OCD report sexual obsessions as their primary symptom (Foa et al., 1995).

Sexual orientation obsessions are a type of sexual obsession that includes worries over experiencing an unwanted change in sexual orientation, fears that others may perceive one as a member of the lesbian, gay, bisexual, transgendersed (LGBT) community, or fears that one has hidden same sex desires (Williams, 2008). Lifetime rates for sexual orientation obsessions in OCD (SO-OCD) are 9.9% and 11.9% among research and treatment-seeking populations, respectively (Pinto et al., 2008; Williams & Farris, 2011). Compared to others with OCD, people with SO-OCD tend to be more strongly correlated with mental compulsions, the need for reassurance, and checking (Williams, Farris, et al., 2011). Despite experiencing greater dysfunction, there is no difference in level of insight exhibited by clients concerning the reasonableness of their obsessional concerns, but people with sexual obsessions may have greater suicidal ideation and experience greater treatment duration than people with other types of OCD (Grant et al., 2006; Williams & Farris, 2011; Williams, Wetterneck, Tellawi, & Duque, 2014). A case study of this specific type of OCD found that exposure and ritual prevention was effective (Ex/RP; Williams, Crozier, & Powers, 2011).

SO-OCD is often included in the broader symptom category of unacceptable/taboo thoughts (e.g., Pinto et al., 2008) or autogenous symptoms, which are egodystonic and come to mind abruptly, without an identifiable trigger (Lee & Kwon, 2003). It was previously believed that people with this type of OCD did not have compulsions, but were considered “pure obsessional” (e.g., Baer, 1994). However, recent work has found that unacceptable/taboo thoughts like SO-OCD tend to be most strongly correlated with mental compulsions, the need for reassurance, and checking (Williams, Farris, et al., 2011).

Sexual Orientation Themed Compulsions

Compulsions associated with SO-OCD may be cognitive, behavioural, or physiological. Mental compulsions, or rituals, include a wide array of cognitive acts (e.g., mental repetition of special words, mental reviewing, mental undoing). Reassurance seeking within the context of SO-OCD may involve checking with others for reassurance, self-assurance, searching the internet for answers, or the need to confess sexual orientation concerns to others (Williams, 2008; Williams, Farris, et al., 2011). This ritual is not often identified or recognised by clients and can be a particularly troubling symptom for those living with the OCD sufferer, as repeated demands for assurance can contribute to family stress (Calvocoressi et al., 1995). Reassurance seeking from partners may mirror the reassurance seeking of individuals with more

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general obsessions about their relationship (Moulding, Aardema, & O’Connor, 2013). Similarly, an individual may engage in physiological checking or somatic checking. A person with SO-OCD may check for signs of sexual arousal when around people of the opposite sex to ensure their heterosexuality, or they may check for signs of non-arousal when around people of the same sex to ensure they have not become LGBT (e.g., Williams, Crozier & Powers, 2011). These testing behaviours can then increase obsessions, as a person may actually experience momentary arousal in response to checking behaviours (Moulding et al., 2013).

Avoidance

Like compulsions, avoidance maintains the disorder and contributes to dysfunction (e.g., Starcevic et al., 2011). People with SO-OCD may avoid situations that provoke the unwanted thoughts, such as gym locker rooms, movies with same sex themes, or even people perceived to be members of the LGBT community. They may avoid dating or sexual activity out of concerns that failure in these endeavours will only prove their fears.

Assessment of Sexual Orientation Symptoms in OCD

Assessing SO-OCD using clinical measures can be difficult, especially if obsessional concerns are restricted to sexual orientation. Few screening instruments specifically address sexual orientation obsessions (Williams, Slinowicz, Tellawi, & Wetterneck, 2014); however, these instruments are still valuable as SO-OCD clients often have obsessive–compulsive symptoms in other areas as well. Measures such as the Yale-Brown Obsessive–Compulsive Scale (Y-BOCS; Goodman et al., 1989) can be important tools in gaining a comprehensive picture of OCD symptomology; however, the Y-BOCS checklist and its successor, the Y-BOCS-II (Storch et al., 2010), have only one question about sexual orientation fears. Therefore, the Y-BOCS cannot be used as a standalone measure to assess these obsessions.

The assessment of OCD in a clinical interview is when sexual orientation obsessions first come to the attention of most clinicians. In some cases, clients may not share their sexual orientation concerns due to shame or catastrophic fears; others may have sought reassurance from numerous clinicians, and, therefore, it is important to inquire about consultations with other clinicians.

Typically, the distress experienced by the client is not related to actual events, but is instead attached to worries about loss of identity as a heterosexual individual—something that is highly valued. The person may fear that the sexual life they have enjoyed (or may someday enjoy) will be suddenly taken away and replaced with something foreign and unappealing (Williams, 2008).

Differential Diagnosis

Differential diagnosis is important, since mental health professionals who do not typically treat OCD clients may attribute the symptoms to an unconscious wish, emerging homosexuality, or difficulties with sexual identity formation (Williams, 2008). A recent study assessed clinicians’ abilities to correctly identify common symptom presentations of OCD (Glazier, Calixte, Rothschild, & Pinto, 2013). Members of the American Psychological Association from each state were randomly selected to participate, and each was assigned to one of five OCD symptom vignettes. When asked to provide a diagnostic impression, 77% misidentified the vignette on obsessions about sexual orientation and classified the problem as sexual identity confusion.

SO-OCD is not the same as ambivalence towards one’s sexual orientation (Gordon, 2002). LGBT individuals who have negative feelings about their sexuality may have internalised homophobia/heterosexism (IH; Szymanski, Kashubeck-West, & Meyer, 2008), and these worries may overlap with SO-OCD. People with IH and individuals with SO-OCD may both fear that LGBT identity represents an end to lifelong dreams of a more socially desirable lifestyle, a traditional wedding, or raising a family (Williams, 2008). Both groups may suffer from anxiety, depression, and low self-esteem, and both may share concerns about being accepted by others (Meyer, 2003). Nevertheless, a person with IH usually has some positive feelings about LGBT identity and will enjoy same sex fantasies, whereas a person with SO-OCD dreads such thoughts and finds them intrusive (Gordon, 2002). People with SO-OCD generally see no consistency between homosexuality and their actual sexual desires. However, it should not be assumed that people with SO-OCD are homophobic/heterosexist, since people with SO-OCD have a wide range of feelings about homosexuality. Additionally, it is possible for LGBT individuals to have unwanted OCD-related sexual orientation obsessions as well (e.g., Goldberg, 1984).

Treatment of SO-OCD

Cognitive Behaviour Therapy

Ex/RP has emerged as a behavioural treatment of choice for OCD, with an extensive body of literature to support its efficacy (Abramowitz, Whiteside, & Deacon, 2005; National Institute for Health and Clinical Excellence, 2005; Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa, & Marin-Martinez, 2008). Below, we review the critical components of Ex/RP and how these are relevant for SO-OCD, and then we discuss mindfulness and acceptance-based approaches that supplement Ex/RP.

Psycho-education. Psycho-education provides a rationale for the nature of treatment to be provided and socialises the client into the treatment process. A general discussion regarding the functional relationship between obsessions and compulsions should be provided to broadly inform individuals about how OCD is maintained.

Next, a discussion of the frequency and nature of the sexually intrusive thoughts within both the general and the clinical population is helpful to normalise the intrusive thoughts. Sexually intrusive thoughts, including those with same sex themes, are common not only in OCD populations, but also in the nonclinical general population (Renaud & Byers, 1999). Thus, sexual thoughts that are LGBT in nature are normative and should not be taken as an indicator of
LGBT sexual identity. Similarly, just as heterosexual individuals may experience thoughts with gay or lesbian thematic content, gay or lesbian individuals may also experience intrusive thoughts with heterosexual content (e.g., Goldberg, 1984).

Individuals with SO-OCD may often erroneously equate sexual arousal with romantic attraction. Addressing this distinction and educating clients on the nature of physiological arousal as something that may be unconnected to actual desire may assist them in placing physiological arousal cues in the appropriate context.

Finally, individuals should be introduced to the pragmatic aspects of treatment, including the use of the Subjective Units of Distress Scale (SUDS; Wolpe, 1969). Situations listed are ranked from least to greatest, as measured by the client’s reported SUDS, with numbers ranging from 0 (no anxiety, calm) to 100 (very severe anxiety, worst ever experienced). Clients start in a challenging but manageable area and then work up to the top of the hierarchy. The use of SUDS ratings allows both the client and therapist to quickly assess perceived levels of distress during the implementation of exposures and monitor progress within and across exposure trials.

In vivo exposures. In vivo exposures should be tailored to the primary obsessional concern and core fear underlying a client’s concerns (Brauer, Lewin, & Storch, 2011).

Common SO-OCD fears include doubting one’s sexual orientation, having same sex romantic experiences, and the fear that others perceive one as having a different sexual orientation. In an in vivo exposure, the therapist and the client work collaboratively to identify specific obsessional triggers to complete the hierarchy and rank each item based on projected SUDS levels. Each client’s hierarchy will be somewhat different (see Table 1 for a hierarchy developed for a woman with SO-OCD concerns).

When implementing exposures, the therapist should start at a lower or a mid-range SUDS point on the hierarchy (i.e., SUDS rating of 50) and guide the client through the exposure during the session. For example, a therapist might elect to start with item #3 (“Political story about LGBT rights”) in the session by providing a politically themed article on LGBT rights and instructing the client to read the article aloud, while monitoring for avoidance behaviours or covert rituals. Generally, the exposure should continue for 30 to 60 minutes, or until the client’s SUDS has decreased by at least half. If the exposure does not evoke a SUDS above 50, or the client habituates after only a few minutes, the therapist may make the exposure more challenging or move to the next item. The in-session exposures are then assigned as daily homework, which will allow the client to practise completing the exposures independently and promote greater generalisation across various environments.

Table 1
Hierarchy for a Female Client with SO-OCD

<table>
<thead>
<tr>
<th>Exposure</th>
<th>SUDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Touch women shoulder to shoulder</td>
<td>30</td>
</tr>
<tr>
<td>2 Looking at own breasts</td>
<td>35</td>
</tr>
<tr>
<td>3 Political story about LGBT rights</td>
<td>40</td>
</tr>
<tr>
<td>4 Being around women</td>
<td>50</td>
</tr>
<tr>
<td>5 Looking at a picture of attractive woman with clothing on</td>
<td>50</td>
</tr>
<tr>
<td>6 Seeing someone breastfeed</td>
<td>50</td>
</tr>
<tr>
<td>7 Looking at masculine / “butch” females</td>
<td>60</td>
</tr>
<tr>
<td>8 Seeing women in low-cut tops/ short skirts</td>
<td>70</td>
</tr>
<tr>
<td>9 Talking to lesbian women</td>
<td>70</td>
</tr>
<tr>
<td>10 Wearing a Gay Pride bracelet</td>
<td>70</td>
</tr>
<tr>
<td>12 A man and woman kissing</td>
<td>75</td>
</tr>
<tr>
<td>13 Imaginal exposure of sexual encounter with a woman</td>
<td>75</td>
</tr>
<tr>
<td>14 Looking at sexy Asian women</td>
<td>80</td>
</tr>
<tr>
<td>15 Hearing “coming out” stories</td>
<td>80</td>
</tr>
<tr>
<td>16 Go to a LGBT club/bar</td>
<td>80</td>
</tr>
<tr>
<td>17 Pictures of bare breasts</td>
<td>85</td>
</tr>
<tr>
<td>18 Lesbian/gay themed shows/movies (e.g., “The L word”)</td>
<td>90</td>
</tr>
</tbody>
</table>
After mastery and competency of lower-level items has been obtained (as demonstrated by between-session habitation accompanied by no ritualising), items rated higher on the hierarchy are selected for exposure. It is important to note that the actual achieved SUDS levels will vary depending on the context and elements of the exposure. For example, item #7 ("Looking at masculine / 'butch' females") may be associated with greater difficulty depending on the length of time the client must look at the individual or the setting in which they are looking at the person.

Item #9 ("Talking to lesbian women") may be conducted by visiting a local gay bar, and the therapist may need to accompany the client initially. In this example, there may be differences in the SUDS rating depending on the location, the number of people in the bar, and how many lesbian women the client must engage in conversation. The client may be directed to interact with LGBT individuals while assuming a temporary LGBT identity (e.g., place themselves in the presumed mindset of an LGBT person and interact accordingly with others, wear clothing the client considers incongruent with her sexual identity).

Imaginal exposures. Imaginal exposures are designed to allow clients to confront the feared catastrophe related to their obsessions that they generally could not otherwise confront. To conduct an imaginal exposure, the therapist and client develop a detailed story about the worst outcome of the client's obsession (Foa, Yadin, & Lichner, 2012). The story will describe a catastrophe that is a direct result of failing to perform rituals. The client is instructed to imagine the scenario as vividly as possible while being confronted with the narrative over and over. The exposure is repeated five times to assure that the story is evoking enough anxiety to be productive. Box 1 presents an imaginal exposure for use in association with item #13 ("Imaginal exposure of sexual encounter with a woman") of our hypothetical client's hierarchy. Several different imaginal exposures may be utilised throughout treatment, with varying catastrophic consequences. Imaginal exposure is particularly effective for those with OCD symptoms that involve a fear of changing in some way, such as the sexual orientation change involved in SO-OCD fears (Gillihan, Williams, Malcoun, Yadin, & Foa, 2012).

Response/ritual prevention. Response prevention involves not engaging in the rituals used to decrease anxiety about an obsession. Response prevention serves to increase exposure time to the stimulus that provokes anxiety (Foa, Steketee, & Milby, 1980), and it is the conjunction of exposure and response prevention together that creates the most effective treatment for OCD (Foa, Steketee, Grayson, Turner, & Latimer, 1984).

Similar to obsessions, rituals in SO-OCD can take many forms, such as reassurance-seeking. The client may ask the therapist, "Do you think I'm gay?!", or seek reassurance from friends and family members. Response prevention would involve the client not indulging in self-assurance or seeking reassurance from others, while being exposed to stimuli that provoke anxiety related to SO-OCD. To help increase awareness of the behaviour the therapist should point out when the client is engaging in a ritual. Once it is clear that the client understands the behaviour is a ritual, the therapist may respond with an exposure statement, such as "You can never be sure " or even "You really are gay!

Individuals with SO-OCD also typically engage in a variety of mental rituals. This may involve thinking positive thoughts to neutralise negative ones. A client may also review or check their memories for times when they did not have SO-OCD concerns as a form of self-reassurance, or remembering when they were sexually attracted to an opposite sex partner. Response prevention would require the client to not engage in these mental rituals during exposures and in daily life. Because these rituals cannot be seen by the therapist, it is important to check in with the client about whether or not they are engaging in rituals during exposure exercises.

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**Box 1**

**Imaginal Exposure Script for Sexual Encounter with a Woman**

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I had been struggling with worries about my sexual orientation for a very long time, and doing all sorts of behaviours to make sure that I was not actually becoming gay. This included going back through my memory to be sure that there were no signs that I was a latent lesbian. I also was constantly checking myself for signs of interest around attractive men and women.

Through the course of getting treated for my OCD, I realised that I was not gay and that all of these behaviours were compulsions. I stopped doing all the rituals and just decided to live my life and let go of the worries. I would stop being vigilant for signs that I might change my orientation.

One day I was at a sports bar in Houston called Nick’s Place. I was watching the world series of the White Sox versus the Astros. A young woman was sitting next to me at the bar and also cheering on my team. She was very beautiful, athletic, with long brown hair and stylish clothes. We started talking and noticed we both liked sports. Her name was Erica and she was also a doctor working at Memorial Hermann Hospital as a paediatric orthopaedic surgeon. It seemed too good to be true to find such an amazing woman that I could really connect with.

I was dating a guy named Ben at the time, and we had been on 10 dates. I really liked him and was thinking about having The Talk, but I found my thoughts drifting to Erica more and more. I decided I was not interested in Ben any longer. I just didn’t feel that spark anymore and he was too agreeable. I can’t really pinpoint what it is that I don’t like and that bothers me. Maybe it is something about me.

I start hanging out with Erica, and I tell her all about Ben. I realise that I feel nervous talking about him because I have a bit of a crush on her. She shares with me that she thinks I should dump Ben for someone who will really know how to love me. I feel the same way, and we start kissing. Eventually one thing leads to another and we are having sex all the time. I spend the night at her place on weekends. I really enjoy our new relationship and realise that I am a lesbian and have been all along. I think if I had kept doing compulsions I would have never discovered this exciting part of who I am.
Clients who have been practising covert rituals for some time may believe it is impossible to simply stop.

Therapists should emphasise that change is a process. Clients should simply do their best, and, as they continue to practise, they will become better at resisting. Clients may also have difficulty distinguishing obsessions from mental rituals. Clinicians can help identify mental rituals by determining the mental processes that the client employs after having an obsessive thought (Gillihan et al., 2012). Another way to teach clients how to distinguish obsessions from mental rituals is to determine the function of their thoughts: obsessions increase anxiety, while compulsions are designed to reduce anxiety. It may be helpful to have clients substitute their mental rituals with exposure statements, such as "I am a lesbian," to prevent engaging in those rituals. If a client does engage in a mental ritual, the therapist can encourage the client to re-expose themselves to the anxiety-provoking stimulus to cancel the anxiety-reducing effects of the ritual. The client should not use statements like "That is my OCD" to combat covert rituals, since such statements can in turn become mental rituals.

As discussed previously, an individual may check for sexual arousal in the presence of an attractive opposite sex individual to determine whether they are still attracted to members of the opposite sex. Conversely, clients may compulsively check to be sure they are not aroused by persons of the same sex, and they should be discouraged from this sort of checking.

Clients with SO-OCD may also engage in overt behaviours, such as watching pornography, in response to obsessions to compare levels of sexual arousal to heterosexual versus same sex sexual activity. Additionally, they may increase their sexual activity to "prove" that they are not LGBT, or they may search the Internet to find reassurance that their sexual orientation will not suddenly change. Response prevention for clients with these overt compulsions involves stopping such behaviours and not overcompensating for possible deficits.

Mindfulness and Acceptance-Based Strategies

Mindfulness and acceptance-based approaches emphasise taking a nonjudgmental stance toward inner experience and focusing on the present moment, despite the present moment including thoughts and feelings that are unwanted. These approaches do not emphasise getting rid of unwanted thoughts. Instead, they encourage the individual to accept such thoughts as a necessary part of human existence (Hayes, Strosahl, & Wilson, 2012). More recently, efforts have been made to assess the effectiveness of mindfulness and acceptance-based strategies in the treatment of OCD (Patel, Carmody, & Simpson, 2007; Twohig et al., 2010). Mindfulness can be used during exposures to help individuals take a nonjudgmental stance toward themselves when they continue to perform rituals even when they are trying not to; this may help to reduce shame or self-judgment during a difficult change process (Fairfax, 2008).

Additionally, mindfulness encourages clients to halt their struggles with their thoughts and accept that avoidance strategies are only helpful in the short term (Didonna, 2009). This helps clients manage their unwanted thoughts by letting go of their struggles or compulsions. Learning to accept SO-OCD thoughts as part of their experience allows clients to better tolerate these thoughts and subsequently reduce compulsions. This also facilitates greater ease in engaging in exposure exercises.

Conclusion

Cognitive behavioural treatments are effective for OCD, including SO-OCD (Williams et al., 2014). However, due to the heterogeneity of this disorder, additional work is needed to ensure the availability of effective treatments for this symptom presentation (Williams et al., 2013). Despite effective behavioural and pharmacological treatments for OCD, there remain many individuals who are unable to access treatment due to a lack of knowledge and misinformation, which may be tragically perpetuated by clinicians. Greater awareness of SO-OCD among mental health professionals and the public is essential to ensure that people with this under-recognised form of the disorder can readily access the help they need.

References


