Pain: Evaluation and Treatment Mitigating Abuse and Addiction Liabilities

WILLIAM S. JACOBS, JR., MD; AND TIMOTHY HUCKABY, MD

Opioids have long been—and continue to remain—important in treating, but their use has increased exponentially over the past 20 years and resulted in near-identical increases in misuse of, abuse of, and addiction to these drugs. This lesson reviews the history of the paradigm shift in opioid prescribing, the scope and extent of the resulting problems associated with that shift, and the evidence of efficacy and safety when chronic non-cancer pain is treated with prescription opioids.

Men’s Health and Sexual Performance

BRIAN KENNETH COOKE, MD; AND MARK S. GOLD, MD

Sexual problems are highly prevalent in men and significantly impact mood, self-esteem, interpersonal functioning, and quality of life. This lesson presents evidence-based practices to provide patient-centered care for adult males.

Sexual Orientation Symptoms in Obsessive Compulsive Disorder: Assessment and Treatment with Cognitive Behavioral Therapy

MONNICA T. WILLIAMS PhD; JOSEPH SLIMOOWICZ, MA; GHAZEL TELLAWI, MA; AND CHAD WETTERNECK, PhD

This lesson shows clinicians how to identify and treat sexual orientation symptoms in obsessive compulsive disorder. If left unaware of the existence of such presentations, clinicians risk misdiagnosing patients, leading to increased distress, worsening symptoms, and treatment delays.

Assessment and Treatment of Social Anxiety Disorder and Selective Mutism in Children and Adolescents

DEBORAH C. BEIDEL, PHD, ABPP; AND BRIAN E. BUNNELL, MS

Social anxiety disorder is characterized by pervasive social inhibition and a fear of negative evaluation by others. It is one of the most commonly occurring psychiatric disorders in children and adolescents. A related condition is selective mutism, described as a withdrawal of speech with non-family members and/or in places outside the home. Once diagnosed, psychological and pharmacological treatments are effective in managing the symptoms of these disorders.

Why the Treatment of Mental Disorders Is an Important Component of HIV Prevention among People Who Inject Drugs

ELIZABETH BUCKINGHAM; EZRA SCHRAGE; AND FRANCINE COURNOS, MD

This lesson discusses the importance of treating mental disorders in persons who inject illicit drugs and/or abuse medications as a means of preventing the proliferation of HIV. By addressing mental disorders, patients are likely to adhere better to antiretroviral treatment and decrease HIV-related risky and addictive behaviors.
Sexual Orientation Symptoms in Obsessive Compulsive Disorder: Assessment and Treatment with Cognitive Behavioral Therapy

Monnica T. Williams, PhD; Joseph Slimowicz, MA; Ghazel Tellawi, MA; and Chad Wetterneck, PhD

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KEY WORDS: Obsessive compulsive Disorder • Anxiety • Treatment • Sexual Obsessions • Homophobia • Heterosexism • Homosexuality

LEARNING OBJECTIVES: Upon completion of this lesson, readers will (1) learn how to distinguish sexual orientation symptoms in OCD (SO-OCD) from a sexual identity crisis or internalized homophobia/heterosexism, (2) consider primary obsessional content among people with SO-OCD, (3) consider primary compulsions experienced by people with SO-OCD and understand how to identify covert/mental compulsions, and (4) review appropriate cognitive behavioral therapy treatment approaches for SO-OCD.

ABSTRACT: Sexual orientation symptoms in OCD (SO-OCD) are common, but under-recognized 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/transgendered (LGBT) community, or fear that one has hidden same-sex desires. In this lesson, research to date on SO-OCD is reviewed, and the phenomenology of SO-OCD is described and contrasted with internalized homophobia/heterosexism (IH). Examples of SO-OCD and related obsessions and compulsions are provided, while the cognitive behavioral treatment of SO-OCD is detailed using psychoeducation, in vivo exposure, imaginal exposure, ritual/response prevention, and 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.

COMPETENCY AREAS: This lesson addresses the gap in knowledge surrounding sexual orientation symptoms in OCD by providing information about how to identify and treat this manifestation of the disorder. If unaware of the existence of such presentations, clinicians risk misdiagnosing patients, leading to increased distress, worsening symptoms, and treatment delays. At the conclusion of this lesson, the readers will have a better understanding of SO-OCD, as well as the strategies to treat SO-OCD using CBT.
Introduction

About Obsessive Compulsive Disorder:

Obsessive compulsive disorder (OCD) is estimated to occur in approximately 2% of the general population.1,2 The hallmark features of this disorder include 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.

From a psychological perspective, the basis upon which OCD pathology emerges and is maintained is encapsulated within the principles of both classical and operant conditioning.3,4 Individuals come to acquire and associate fear and anxiety in response to obsessions through classical conditioning,5 whereas behavioral compulsions are maintained through operant conditioning via the application of positive or negative reinforcement. Within the context of OCD, compulsions provide negative reinforcement by affording the temporary relief of negative affects.

While compulsive rituals may initially relieve the anxiety and suffering associated with obsessions, they actually reinforce the behavior, thus increasing the likelihood of future compulsive behavior in response to obsessions. The continued use of compulsions to reduce associated anxiety creates a reinforced behavioral response, which becomes increasingly more entrenched and difficult to resist, leading to increased impairment and decreased day-to-day functioning.

Sexual Orientation Obsessions:

Much research has been conducted on primary symptom presentations that involve checking and contamination concerns (Ball, Baer, & Otto, 1996);6 however, sexual obsession is one area that has received little attention.7 Similar to other types of obsessions, sexual obsessions can take various forms; for example, they may include fears of being attracted to children, fears of engaging in inappropriate sexual activity, or intrusive sexual images. Approximately 10.5% of patients seeking treatment for OCD report sexual obsessions as their primary symptom.8 One form of sexual obsession that has received even less attention in the literature is that of sexual orientation obsessions, which 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/transgendered (LGBT) community, or fears that one has hidden same-sex desires (SO-OCD, sometimes called HOCD).9 Lifetime rates for sexual orientation obsessions in OCD have been reported at 9.9% and 11.9% among research and treatment-seeking populations, respectively.10,11 One study that specifically examined sexual orientation obsessions in a large sample involved patients enrolled in the DSM-IV field trial of OCD.8 Williams and Farris (2011) found that, compared to others with OCD, people with SO-OCD spent significantly more time obsessing, experienced more interference from the obsessions, experienced greater distress, and demonstrated some increased avoidance behaviors.11 Despite the relatively greater dysfunction caused by sexual orientation obsessions, there was no difference in the level of insight exhibited by patients concerning the reasonableness of their obsessional concerns. It was concluded that this increased dysfunction may be clinically relevant for the assessment and treatment of OCD, and that behavioral treatment may need to be specifically tailored to this particular group of patients. People with sexual obsessions appear to spend more time in treatment than people with other types of OCD,12 but it is not clear if this is the case for SO-OCD specifically. A case study of this specific type of OCD found that exposure and ritual prevention using a typical treatment protocol was effective.13

To better understand the nature of SO-OCD, Williams, Tellawi, and Wetterneck (2011c) conducted an Internet study of 1,176 participants that supported these clinical observations.14 Of those participants with SO-OCD symptoms (based on reports of previous OCD diagnoses, sexual orientation, and distress surrounding sexual orientation worries), a principal components analysis identified four components: worries about becoming gay, the belief that being gay is bad or immoral, worries about being attracted to the opposite sex, and finding same-sex thoughts upsetting. Each of these components was significantly correlated to the overall level of distress. The vast majority reported a
very high level of distress, with 52% reporting "extreme" distress and 19% reporting a "suicidal" level of distress.

**Sexual Orientation Compulsions:**

SO-OCD is often included in the broader symptom category of unacceptable/taboo thoughts (e.g., Pinto et al., 2008). It was previously believed that people with this type of OCD did not have compulsions; instead, they were considered “pure obsessional” (e.g., Baer, 1994). No studies have examined exactly what types of compulsions are most common among those with SO-OCD, but recent work has found that unacceptable/taboo thoughts tend to be most strongly correlated with mental compulsions, the need for reassurance, and checking. SO-OCD appears to be no exception.

**Mental Compulsions**

Mental compulsions, or rituals, can include a wide array of cognitive acts (e.g., mental repetition of special words, mental reviewing, mental undoing). An example of a mental ritual (for a female) could be repeating to oneself, “I don't like girls, Mom knows I don't like girls, and my friends know I don't like girls,” every time the person is bothered by a sexual orientation obsession. The person may also mentally review experiences with the opposite sex to convince herself that she enjoyed experiences with males, thus confirming her heterosexuality. One male patient treated by the author (MTW) would try to visualize two men kissing, and if he felt a negative visceral reaction, he was (temporarily) satisfied that he was not turning gay. If he didn't feel the reaction, he had to repeat the imagery.

**Reassurance Seeking**

Reassurance seeking is a ritual that is often not identified or recognized as a compulsion by patients. Reassurance can be sought in many forms, including asking others for reassurance, self-assurance, searching the Internet for answers, or the need to confess to others (Williams et al., 2011). This can be a particularly troubling symptom for those living with the OCD sufferer, as repeated demands for reassurance can contribute to family stress.

**Somatic Checking**

Somatic checking can be best described as checking one's body for signs of illness. For example, someone with illness anxiety may constantly check themselves for signs of fever, disease, or high blood pressure to ensure that they are not becoming ill. Likewise, 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 gay (e.g., Williams, Crozier, & Powers, 2011). For example, a male with SO-OCD might watch homosexual pornography to be sure that it is not as enjoyable as straight pornography. If he feels any signs of sexual arousal when viewing the gay pornography, he may repeat the compulsion until the arousal goes away and he is satisfied that he has not become gay.

**Avoidance**

Avoidance is not considered a compulsion *per se*, but it nonetheless maintains the disorder and contributes to dysfunction. People with SO-OCD may avoid situations that provoke the unwanted thoughts, such as locker rooms, movies with same-sex themes, or even people perceived to be members of the LGBT community.

**Assessment of Sexual Orientation Symptoms in OCD:**

**Assessment Using Clinical Measures**

Assessing SO-OCD using clinical measures can be difficult, as few screening instruments for OCD specifically address sexual orientation obsessions. However, these instruments are still valuable because it is very likely that an SO-OCD patient will have obsessive-compulsive symptoms in other areas as well. Measures such as the Obsessive-Compulsive Inventory’s short version (OCI-R; Foa et al., 2002) and the Yale-Brown Obsessive-Compulsive Scale Checklist and Severity Rating Scale (Y-BOCS) can be important tools in gaining a comprehensive picture of OCD symptomology, although the 60-item Y-BOCS Checklist has only one question about sexual orientation fears, and the 18-item OCI-R has no questions that address this specific obsession or any specific sexual obsession.
New assessment measures are being developed to better capture the dimensionality inherent in OCD. Two of the most recent measures are the Dimensional Obsessive-Compulsive Scale (DOCS)\textsuperscript{21} and the Obsessional Intrusive Thoughts Inventory (INPIOS).\textsuperscript{22,23} Recent studies using these measures have found that different obsessive beliefs known to be endorsed by individuals with OCD relate to the various symptom dimensions in a meaningful way.

It is unlikely that the current DOCS will adequately capture SO-OCD symptoms because it focuses on a single, broad “Unacceptable Thoughts” category, which includes anxiety about morality, violence, repeating, mental actions, mental prayers, and avoidance, as well as sexual concerns. Moreover, although sexual concerns are listed, no specific mention is made of sexual orientation obsessions. The DOCS for Sexually Intrusive Thoughts (DOCS-SI),\textsuperscript{24} which is a variation of the DOCS focused on sexual obsessions, may better help to capture those with SO-OCD.

**Assessment Using a Clinical Interview**

The assessment of SO-OCD in a clinical interview is how the disorder first comes to the attention of most clinicians. Many who seek treatment for SO-OCD are unaware that they are suffering from a form of OCD. They may initially present with a long narrative about how they are not gay and have always been attracted to the opposite sex, before revealing their SO-OCD worries. In addition, they may continually ask the clinician for reassurance and feel the need to provide excessive information (e.g., “So, do you think I’m gay? But wait, before you answer, let me tell you about one more thing I am worried about…”)  

In some cases, the patient may not have shared their concerns with anyone else due to shame or catastrophic fears that may be out of proportion with reality (e.g., “If anyone knew I had these thoughts, my life would be over and I would lose my job and my family.”) However, in other cases, the patient may have sought out opinions from numerous clinicians as a reassurance compulsion, so it is important to inquire about anyone else the patient may have consulted about the problem.

Typically, the distress experienced by the individual is not related to any actual events that have occurred, but is instead attached to the worry that the patient will lose access to the opposite sex—something that is highly valued. The person may fear that the sexual life s/he has enjoyed (or may someday enjoy) will suddenly be taken away and replaced with something foreign and unappealing.\textsuperscript{9}

**Differential Diagnosis**

Differential diagnosis is important, since mental health professionals who do not typically treat OCD patients may fail to properly diagnose a patient complaining of unwanted sexual obsessions. Therapists may attribute the symptoms to an unconscious wish, emerging homosexuality, or difficulties with sexual identity formation. This conceptualization of the problem may cause panic in an already distressed individual, resulting in the patient becoming even more upset and confused.\textsuperscript{7}

A recent study assessed clinicians’ abilities to correctly identify common symptom presentations of OCD.\textsuperscript{25} 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 give a diagnostic impression, 77.0% misidentified the vignette on obsessions about sexual orientation and classified the problem as sexual identity confusion. In contrast, only 15.8% misidentified contamination obsessions as being indicative of OCD, and 28.8% misidentified religious obsessions as part of the disorder. Of the respondents, 81.8% were doctoral-level psychologists, 81.3% were licensed, and over half reported a cognitive-behavioral orientation. When attempting to identify OCD-related sexual orientation obsessions, as in the vignette, the key issue to understand is that the unwanted sexual thoughts are ego-dystonic or ego-alien, meaning that the obsessions are inconsistent with the individual’s fundamental desires, fantasies, and sexual history.

SO-OCD is not the same as ambivalence towards one’s sexual orientation.\textsuperscript{7} LGBT individuals who have negative feelings about their own sexuality may be diagnosed with internalized homophobia/heterosexism (IH),\textsuperscript{26} and these worries may overlap with SO-OCD. People with IH and individuals with SO-OCD may fear that homosexuality represents an end to lifelong dreams of a more socially desirable lifestyle, a traditional wedding,
or raising a family; in fact, these are concerns that many LGBT individuals work to process as they accept their orientation. Both groups may suffer from anxiety, depression, and low self-esteem, and both may share concerns about being accepted by others. Nevertheless, a person with IH usually has some positive feelings about homosexuality and will enjoy same-sex fantasies, whereas a person with SO-OCD dreads such thoughts and finds them intrusive. People with SO-OCD generally see no consistency between homosexuality and their actual sexual desires, though they may have no problems with others who are LGBT. It should not be assumed that people with SO-OCD are homophobic, since people with SO-OCD have a wide range of feelings about homosexuality.

To complicate matters, it is possible for LGBT individuals to have unwanted OCD-related sexual orientation obsessions as well (e.g., Goldberg, 1984). For example, a gay male may obsess about how a heterosexual relationship would affect his gay identity and worry about being rejected by his peers if he were attracted to a woman. In another example, a happily married woman with bisexual tendencies may fear losing interest in her husband in favor of another woman. These types of worries may occur for reasons unrelated to OCD, but what distinguishes OCD-related concerns from reasonable concerns is an unwarranted focus on the possibility of these events happening, even when the person’s actual circumstances do not make them particularly likely to occur.

Treatment with Cognitive Behavioral Therapy

Exposure and ritual/response prevention (EX/RP) has emerged as a CBT treatment of choice for obsessive-compulsive disorder (OCD), with an extensive body of literature to support its efficacy in both pediatric and adult populations. Below, we review the critical components of EX/RP and how these are tailored to SO-OCD, and then we discuss mindfulness and acceptance-based approaches that supplement EX/RP.

Psychoeducation:

Psychoeducation provides a rationale for the type of treatment to be provided and socializes the patient into the treatment process. Given the reluctance of some individuals to engage in EX/RP due to the intrinsically aversive nature of exposures, a solid psychoeducational background prepares patients for later stages of treatment by providing them with a framework and understanding of the rationale for engaging in EX/RP.

A discussion of the frequency and nature of the sexually intrusive thoughts within both the general and the clinical population may assist individuals with SO-OCD in normalizing the nature of intrusive thoughts, thus facilitating a decrease in distress associated with having these obsessions. Sexually intrusive thoughts have been demonstrated to be present, not only in OCD populations, but also in the non-clinical general population. In a sample of college students, both men and women experienced thoughts about engaging in sexual activity inconsistent with their sexual orientation, and 50% of males and 43% of females classified these thoughts as being negative (Renaud & Byers, 1999). Thus, having intrusive sexual thoughts that are LGBT in nature is 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.

Other main discussion points for psychoeducation include a review of the major cognitive components that maintain SO-OCD, such as thought suppression, thought-action fusion (TAF), over-valuation of the importance of thoughts within the context of OCD, and information regarding the differences between sexual arousal and sexual attraction. Thought suppression refers to the paradoxical effect that occurs when an individual attempts to suppress or avoid a thought, which often results in an increase of the occurrence of such a thought. For example, individuals with SO-OCD may experience intrusive thoughts relating to the genitalia of same-sex individuals and, in response, attempt to suppress and avoid such thoughts. Paradoxically, attempts to avoid these thoughts may lead to an increase in such unwanted thoughts.

TAF refers to the belief that having certain thoughts will increase the likelihood and possibility of actually carrying out such thoughts. For example, individuals with SO-OCD may experience thoughts relating to
impulses to kiss or inappropriately touch other members of the same sex. These thoughts may be misinterpreted as indicators that the likelihood of engaging in these actions is greater simply because they are experiencing such thoughts. Providing individuals with information regarding TAF and discussing the importance of the thoughts and subsequent evaluations of those thoughts may assist them in modifying erroneous cognitions by placing intrusive thoughts in a more realistic light. Thoughts may be framed as simply thoughts, rather than as indicators of the likelihood of engaging in such behaviors, or as latent desires/wishes to engage sexually with members of the same sex. Furthermore, intrusive thoughts with sexual orientation themes may simply indicate that opposite-sex relationships, reputation, faith, and sexual identity are prized and important aspects of the individual’s being.9

Moreover, individuals with SO-OCD may often erroneously equate sexual arousal with romantic attraction. As a result, such individuals may engage in rituals such as checking somatic sensations and experiences for indications of arousal following exposure to feared external environmental stimuli. Addressing this distinction and educating patients on the nature of physiological arousal as something unconnected to actual desire may assist them in placing physiological arousal cues in the appropriate context.

A general discussion regarding the functional relationship between obsessions and compulsions should also be provided to broadly inform individuals about how OCD is maintained. Obsessions give rise to compulsions, which initially reduce the distress associated with intrusive thoughts. While compulsions may initially be adequate for reducing distress associated with intrusive thoughts, over time, these compulsions give rise to greater levels of functional impairment in important areas of functioning. Engaging in cognitive and behavioral aspects of treatment for OCD allows the modification of factors that maintain OCD, such that intrusions are eventually viewed as appropriately benign rather than laden with meaning.

Finally, individuals should be introduced to the pragmatic aspects of treatment, including the use of the subjective units of distress scale (SUDS).37 The use of the SUDS ratings throughout treatment allows for an initial assessment of feared situations, which facilitates the development of an exposure hierarchy. The situations listed are ranked from least to greatest, as measured by the patient’s reported SUDS, with numbers ranging from 0 (no anxiety, calm) to 100 (very severe anxiety, worst ever experienced), and patients start in a challenging but manageable area and then work up to the top of the hierarchy. During this process, anchor points are typically created as an objective basis for assessing general distress. Anchor points should consist of non-OCD-related anxiety-provoking situations to allow the patient to objectively evaluate his or her distress in OCD-related anxiety-provoking situations. The use of SUDS ratings allows both the patient and clinician to quickly assess perceived levels of distress during the implementation of clinician-assisted and independent “homework” exposures that 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 patient’s concerns.38 Common SO-OCD fears include doubting one’s sexual orientation (and potentially acting on this doubt) and the fear that others perceive one as having a different sexual orientation. In an *in vivo* exposure, the clinician and the patient work collaboratively to identify specific obsessional triggers to complete the hierarchy, and rank each item based on projected SUDS levels. Although every patient's hierarchy will be somewhat different, Table 1 lists a sample hierarchy developed for SO-OCD concerns.

When implementing the exposures, the therapist should start at a lower or a mid-range SUDS point on the hierarchy (about 50) and guide the patient through the exposure during the session. For example, a therapist might elect to start with Item #3 in the session by providing a pen and paper and instructing a heterosexual patient to write “I am gay” repeatedly on a sheet of paper, while monitoring the patient for avoidance behaviors or covert rituals. Subtle avoidance behaviors, such as the patient not focusing on the words “I am gay” being written on the paper, shaking his or her head in disapproval, or joking about the task, may appear. Generally, the exposure should continue for 30 to 60 minutes, or until the
patient’s SUDS has decreased by at least half. If the exposure is too easy (i.e., it does not evoke SUDS above 50, or the patient habituates after only a few minutes), the therapist may alter the exposure by having the patient write variations on the theme, such as, “I’m sure I am gay. I love being gay. I want to have sex with men. I hope I am gay forever.” The in-session exposures are then assigned as daily homework, which will allow the patient to practice completing the exposures independently and promote greater generalization across various environments.

After mastery and competency of lower-level items has been obtained (as demonstrated by between-session habituation and no ritualizing), 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 of the exposure and the modification of elements of the exposure. For example, Item #7 (i.e., wearing a gay pride bracelet) may be associated with greater difficulty depending on the length of time the bracelet is worn, the setting in which it is worn (e.g., at home versus in a social setting), and with whom the bracelet is worn (e.g., close friends versus strangers). Modifications to exposures should occur as needed to ensure that the targeted SUDS level is reached (generally at least 50 for in-session exposures).

Imaginal Exposures:
Imaginal exposures are designed to allow patients to confront the feared catastrophe related to their obsessions that they generally could not otherwise confront. To conduct an imaginal exposure, the therapist and patient develop a detailed story about the worst outcome of the patient’s obsession. The story will describe a catastrophe that is a direct result of failing to perform rituals, and the patient is instructed to close their eyes and imagine the scenario as vividly as possible while being confronted with the narrative over and over. The exposure is typically recorded to facilitate repeated listening during the session and as homework. SUDS levels are assessed every five minutes to assure that the story is evoking enough anxiety to be productive.

An imaginal exposure appears on our hypothetical patient’s hierarchy as Item #13 (Table 1). Several different imaginal exposures may be utilized throughout treatment, with varying catastrophic consequences. Imaginal exposure is particularly effective for those with OCD symptoms, such as SO-OCD. See Table 2.

Response Prevention:
A major component of EX/RP is response prevention, which 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, and it is the conjunction of exposure and response prevention together that creates the most effective treatment for OCD.

Similar to obsessions, rituals in SO-OCD can take many forms. A frequent ritual is reassurance seeking.
Individuals with SO-OCD may think, “What if I am gay?” and reassurance seeking might take the form of thinking, “No, I’ve always been attracted to the opposite sex,” or involve seeking reassurance from others. The patient may ask the therapist, “Do you think I’m gay?” or seek reassurance from friends and family members. Response prevention would involve the patient not necessitating in self-assurance or seeking reassurance from others, while being exposed to stimuli that provoke anxiety related to SO-OCD. The therapist should point out to the patient when s/he is engaging in a ritual in order to help the patient increase awareness of the behavior. Once it is clear that the patient understands that his or her behavior is a ritual, the therapist may respond with an exposure statement, such as “You might be gay,” “You can never be sure,” or even “I really do think you are gay!”

Individuals with SO-OCD also typically engage in a variety of mental rituals. One ritual may involve thinking positive thoughts to neutralize negative ones. For example, a patient might neutralize the thought of “I am going to have to give up opposite-sex relationships” with an opposite positive thought. A patient may also review or check his or her memories for times when s/he did not have SO-OCD concerns as a form of self-reassurance, remembering when they were sexually attracted to an opposite-sex partner. Response prevention would require the patient to not engage in these mental rituals during exposures, and in general. Because these rituals cannot be seen in-session by the therapist, it is important to check in with the patient about whether or not s/he is engaging in rituals during exposure exercises.

Patients who have been practicing covert rituals for some time may believe it is impossible to simply stop. Therapists should emphasize that change is a process.

Table 1: Sample Hierarchy for a Male Patient with Sexual Orientation Themed OCD (SO-OCD)

<table>
<thead>
<tr>
<th>Exposure</th>
<th>SUDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Watch lesbian-themed movie “Kissing Jessica Stein”</td>
<td>35</td>
</tr>
<tr>
<td>2 Have sex with girlfriend without checking self</td>
<td>40</td>
</tr>
<tr>
<td>3 Write “I am gay” over and over</td>
<td>45</td>
</tr>
<tr>
<td>4 Make a gay profile of self on an online dating site (anonymous)</td>
<td>50</td>
</tr>
<tr>
<td>5 Wear “gay looking” clothes in public</td>
<td>50</td>
</tr>
<tr>
<td>6 Joke to friends that you are gay</td>
<td>50</td>
</tr>
<tr>
<td>7 Wear gay pride bracelet (at home and at a store)</td>
<td>55</td>
</tr>
<tr>
<td>8 Stare at pictures of attractive men in stylish clothes</td>
<td>60</td>
</tr>
<tr>
<td>9 Buy LGBT magazine/reading material</td>
<td>60</td>
</tr>
<tr>
<td>10 Watch movie “Philadelphia” or “The Crying Game”</td>
<td>60</td>
</tr>
<tr>
<td>12 Watch gay-themed movie “Brokeback Mountain”</td>
<td>70</td>
</tr>
<tr>
<td>13 Record and listen to a story about yourself becoming gay</td>
<td>80</td>
</tr>
<tr>
<td>14 Talk to gay men on an online dating site</td>
<td>80</td>
</tr>
<tr>
<td>15 Watch gay pornography</td>
<td>85</td>
</tr>
<tr>
<td>16 Have a conversation with a gay person</td>
<td>90</td>
</tr>
<tr>
<td>17 Go to a local gay club and chat with people</td>
<td>90</td>
</tr>
<tr>
<td>18 Go to an LGBT club meeting on campus</td>
<td>99</td>
</tr>
</tbody>
</table>
and that they should simply do their best. As patients continue to work at changing, they will become better at resisting. Patients may also have difficulty distinguishing obsessions from mental rituals. Clinicians can help identify mental rituals by determining the mental processes that the patient employs after having an obsessive thought. Another way to teach patients how to distinguish obsessions from mental rituals is to ask them the function of their thoughts: obsessions increase anxiety, while rituals are designed to reduce anxiety. This can help patients understand that they can have thoughts that cause anxiety, but should refrain from the thoughts that are meant to decrease anxiety. It may be helpful to have patients substitute their mental rituals with exposure statements, such as “I am gay,” to prevent them from engaging in those rituals. If a patient does engage in a mental ritual, the clinician can have the patient re-expose him or herself to the anxiety-provoking stimulus in order to cancel the effects of the ritual. One thing not to do is to teach the patient to use self-statements, like “That is my SO-OCD,” to pinpoint their covert rituals, since such statements can then become mental rituals. Instead, the clinician should teach the patient to use an exposure statement that targets the fear of becoming gay, such as a male patient saying, “I am attracted to men.”

Another category of ritual in SO-OCD is somatic checking. The individual may check for sexual arousal in the presence of an attractive opposite-sex individual to determine whether s/he is still attracted to members of the opposite sex. Conversely, a patient may check to see whether s/he is aroused by persons of the same sex. Patients with SO-OCD may also engage in overt behaviors in response to their obsessions. They may watch same-sex pornography and opposite-sex pornography to compare levels of sexual arousal or to see whether they are aroused by same-sex pornography. They may
increase their levels of sexual activity to “prove” that they are not LGBT. They may surf the Internet to find reassurance that their sexual orientation won’t change. Response prevention for patients with these overt compulsions involves stopping such behaviors and not over-compensating for perceived deficits.

**Mindfulness and Acceptance-Based Approaches:**

Mindfulness and acceptance-based approaches emphasize taking a non-judgmental 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 emphasize altering or getting rid of unwanted thoughts. Instead, they encourage the individual to accept such thoughts as a necessary part of human existence. Specifically, in Acceptance and Commitment Therapy (ACT), the goal of treatment is to increase psychological flexibility. The ACT theory holds that psychological flexibility is composed of six core processes, known as the “hexaflex.” These six processes are: flexible attention to the present moment, values, committed action, self-as-context, defusion, and acceptance. Flexible attention to the present moment involves the individual contacting the present voluntarily and in a focused way. Values are directions in life that the individual chooses in multiple areas, such as family or education, which then become the goals that guide the individual. Committed action occurs when patients choose long-term patterns of behavior that help them strive toward their values. Self-as-context involves helping patients learn that they can have experiences without being attached to them. Defusion is when individuals are able to change the way in which they interact with their inner experience, which can lessen their negative judgments of their own experiences. Acceptance is when individuals can experience their private experiences without struggling against them. Treatment with ACT targets all six of these processes in an attempt to increase psychological flexibility.

In recent years, a push has been made to assess the effectiveness of mindfulness and acceptance-based strategies in the treatment of OCD. Fairfax (2008) states that 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.

In the treatment of OCD, a mindfulness approach would involve altering the way patients relate to their inner experience. Individuals with OCD have unwanted thoughts and use behavioral strategies to avoid the anxiety related to these thoughts. In mindfulness, this avoidance is called experiential avoidance (EA), and it involves efforts to change the content, amount, or sensitivity of challenging private events, such as cognitions and emotions, even though these efforts result in actions that are inconsistent with an individual’s values and goals (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). EA is clearly a key issue in the treatment of OCD, as many compulsions are employed to avoid certain thoughts. Furthermore, mindfulness approaches can help target the TAF that typically occurs in OCD, in which a person believes that thinking about an occurrence makes it more likely that the occurrence will actually happen. This relates to the ACT concept of fusion, in which thoughts are so intertwined with external experience that an individual is unable to discriminate between the two. When people are in a fused state, their thinking is the only thing that guides their behavior. Therefore, when he or she is in a situation that involves unpleasant inner experiences, a fused individual will engage in strategies to avoid those experiences that are seen as “unhealthy.” In terms of OCD, a person may experience an obsession and immediately label it “unhealthy,” which would result in compulsions to escape unwanted emotions in the short term. However, fusion may interfere with a person’s awareness, and the person may not realize that engaging in compulsions may interfere with the ability to behave in a way that is directed toward internal values.

Additionally, mindfulness encourages patients to halt their struggles with their thoughts and accept that EA strategies are only helpful in the short term. This helps patients manage their unwanted thoughts by letting go of their struggles, which, in OCD, take the form of compulsions. Specifically, for SO-OCD, acceptance and mindfulness can help manage the unwanted thoughts of being or becoming LGBT. Learning to accept SO-OCD thoughts as part of their experiences allows individuals to better tolerate these thoughts and
subsequently reduce compulsions. This also facilitates greater ease in engaging in exposure exercises. Moreover, mindfulness is helpful in teaching individuals not to engage in evaluations, judgments, or appraisals of their thoughts. This is specifically important in the treatment of SO-OCD because of the current stigma towards individuals who identify as LGBT. Reducing the negative appraisal of unwanted thoughts about sexual orientation helps patients reduce the distress caused by these thoughts.

Conclusions

Treatment Outcomes:
Systematic research has helped to develop excellent CBT treatments for OCD. However, due to the many presentations of this disorder, additional work is needed to ensure the availability of maximally effective treatments for each of the primary symptom presentations. Treatment manuals for OCD tend to address symptoms more generally, since it would be cumbersome to include detailed approaches for each possible symptom in a single manual. However, given empirical differences in phenomenology, cognitions, and even numbers of required sessions, manuals focused on specific symptom presentations may facilitate improved treatment outcomes. Although EX/RP uses the same principles for all forms of OCD, it is helpful for clinicians to have intervention materials with highly relevant examples of exposures and information about research findings specific to SO-OCD.

Improved Awareness and Diagnosis:
Despite effective behavioral and pharmacological treatments for OCD, there remain many sufferers who are unable to access these treatments due to a lack of knowledge and misinformation, which may be tragically perpetuated by clinicians. Greater awareness of SO-OCD among both mental health professionals and patients is essential to ensure that people with this form of OCD can access the help they need.

Much-needed work in this area includes the development of new measures that can be used to reliably differentiate those with SO-OCD from those with sexual identity confusion or others who may be insecure in their LGBT identity. Such an instrument could provide clinicians with a diagnostic tool to quickly identify SO-OCD. Moreover, it may provide a way to quantify the presence of distress resulting from SO-OCD in research on this OCD symptom dimension, and provide insight into variables that affect the development, maintenance, and treatment of these symptoms.

About the Faculty

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References


Best Practices in CME

Sexual Orientation Symptoms in Obsessive Compulsive Disorder: Assessment and Treatment with Cognitive Behavioral Therapy

By Monnica T. Williams, PhD; Joseph Slimowicz, MA; Ghazel Tellawi, MA; and Chad Wetterneck, PhD
ID #: L003325

This valuable take-home reference translates evidence-based, continuing medical education research and theory, acquired from reading the associated CME lesson, into a step-wise approach that reviews key learning points for easy assimilation into your armamentarium of knowledge and daily practice.

CME Lesson Overview

This lesson provides the fundamental knowledge necessary when treating sexual orientation concerns in OCD. The faculty present backgrounds in understanding the nature of SO-OCD, assessment methods, and cognitive behavioral intervention methods. Clinicians should have a better understanding of the nature of sexual orientation OCD and appropriate methods of treatment upon completion of the lesson.

Key Point 1: Background
Sexual orientation is a commonly expressed obsessional concern in individuals with OCD.

Key Point 2: Differential Diagnosis
Providers may often make the mistake of confusing associated SO-OCD symptoms with sexual orientation identity concerns.

Key Point 3: Exposure/Ritual Prevention is the Best Treatment
SO-OCD should be treated in a manner consistent with gold standards of empirically-based treatment utilizing exposure and ritual/response prevention that is tailored to the unique symptoms, obsessional concerns, and compulsions of the patient.

Key Point 4: Other CBT Approaches
Treatment of SO-OCD may also include other approaches such as cognitive therapy, mindfulness, and Acceptance and Commitment Therapy (ACT).

Key Point 5: Future Direction
Continued research is needed to add to the relatively scant research on this particular subtype of OCD. Assessment methods such as self-report forms to reliably and validly assess for OCD must be developed at this time.