
Treatment of Sexual-Orientation Obsessions in Obsessive-Compulsive Disorder Using Exposure and Ritual Prevention

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Abstract

Presented is a case report of exposure and ritual prevention (EX/RP) therapy administered to a 51-year-old, White, heterosexual male with sexual-orientation obsessions in obsessive-compulsive disorder (OCD). The patient had been previously treated with pharmacotherapy, resulting in inadequate symptom reduction and unwanted side effects. OCD symptoms included anxiety about the possibility of becoming gay, mental reassurance, and avoidance of other men, which resulted in depressive symptoms and marital distress. The patient received 17 EX/RP sessions, administered twice per week. The effect of treatment was evaluated using standardized rating instruments and self-monitoring by the patient. OCD symptoms on the Yale-Brown Obsessive Compulsive Scale (YBOCS) fell from 24 at intake to 3 at posttreatment and to 4 at a 6-week follow-up, indicating minimal symptoms. Improvement also occurred in mood, quality of life, and social adjustment. Issues concerning the assessment and treatment of homosexuality-themed obsessions in OCD are highlighted and discussed.

Keywords

obsessive-compulsive disorder, case study, cognitive-behavioral therapy, sexual obsessions, sexual orientation, treatment, exposure and response prevention, homosexuality

I Theoretical and Research Basis

Obsessive-compulsive disorder (OCD) is estimated to occur in 1.6% to 2.3% of the general population (Kessler et al., 2005; Ruscio, Stein, Chiu, & Kessler, 2010). It is a disorder marked by significant distress and interference in daily activities. The hallmark features of this disorder include both obsessions and compulsions. Obsessions are intrusive thoughts, impulses, or images

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that cause distress and increased anxiety. Compulsions are behaviors performed to decrease anxiety or distress associated with obsessions and may be either mental or physical. Both obsessions and compulsions come in many different forms and each individual's symptom presentation is different. Obsessive thoughts can range from the fear of becoming ill due to contamination to fear of harming one's child. Similarly, compulsions can include everything from repeated and excessive hand washing to mentally reviewing the child's daily activities to ensure that the child was not accidentally harmed during the day.

Many studies have been conducted to describe subtypes of OCD across different symptom clusters, and there has been some agreement between researchers as to which symptoms tend to cluster together. Typical OCD symptom clusters include harming fears, contamination fears, unacceptable thoughts, symmetry/arranging, and hoarding symptoms (Abramowitz, Franklin, Schwartz, & Furr, 2003). Much research has been carried out on primary symptom presentations that include checking and contamination concerns (Ball, Baer, & Otto, 1996), but one area that has seen little research has been the sexual obsessions (Gordon, 2002). Similar to other types of obsessions, sexual obsessions can take many different forms. For example, this type of obsession could include fears of molesting a child, fears associated with sexual orientation, fears of engaging in inappropriate sexual activity, or intrusive sexual images. As with all obsessions, sexual obsessions must be considered intrusive and unwanted and should not include sexual thoughts or images that the patient finds pleasurable. Some examples of compulsions that might accompany sexual obsessions include checking arousal levels to determine attraction, maintaining sufficient physical distance from others to ensure that inappropriate touching does not occur, or mental reassurance that one is not sexually deviant.

The limited research into this topic has shown that approximately 10.5% of treatment-seeking OCD patients report sexual obsessions as their primary symptom (Foa et al., 1995). Current and lifetime prevalence of sexual obsessions among this group, regardless of whether they are considered a primary symptom, is 16.8% and 26.3%, respectively (Williams & Farris, IN PRESS). Given these rates, it appears that such obsessional content is common in OCD. One particular form of sexual obsessions that has received even less attention in the literature is sexual-orientation fears, which may include a fear of experiencing an unwanted change in sexual orientation, fear that others may perceive that one is homosexual, or fear that one has latent homosexual desires. Lifetime rates for homosexual obsessions have been reported at 9.9% and 11.9% among research and treatment-seeking populations, respectively (Pinto et al., 2008; Williams & Farris, IN PRESS). To date, the only published work on homosexual obsessions has been a qualitative book chapter (Williams, 2008). This dearth of literature may be reflective of the often misunderstood nature of homosexual obsessions and sexual obsessions more generally. Sexual obsessions are often misdiagnosed or missed completely by clinicians who are unfamiliar or inexperienced with this form of OCD (Gordon, 2002). It is important to note that sexual obsessions are very different from thoughts and fears an individual might experience if he or she was conflicted about his or her sexual orientation and are not simply a reflection of the individual's sexual attraction to a particular gender.

Although homosexual obsessions are an often misunderstood symptom of OCD, the treatment—exposure and ritual prevention (EX/RP) therapy (Kozak & Foa, 1997)—follows the same structure as any other form of OCD, although there is some evidence that those with sexual obsessions may spend more time in therapy than those without these symptoms (Grant et al., 2006). EX/RP is a form of cognitive behavioral therapy that has been empirically supported for use with OCD (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000). From a cognitive behavioral perspective, obsessions are maintained through use of rituals that serve to decrease the anxiety or distress the individual feels as a result of the intrusive obsession. Because the ritual immediately reduces the distress, the individual fails to learn that the obsession does not represent a real threat. Without

such awareness, the individual comes to believe that the ritual is the only means by which to decrease the anxiety felt following an obsession while reinforcing the danger that the obsession represents. EX/RP therapy is a two-pronged approach that aims to expose the patient to the feared stimulus (the object of the obsession) while eliminating the ritual. Through this process, the patient is able to learn that the feared outcome is unlikely to occur even when a ritual has not been performed (Kozak & Foa, 1997).

In the case of a patient with sexual-orientation obsessions, the process remains the same. The patient is asked to expose himself to the feared stimulus, that is, he might be homosexual, and to also refrain from any rituals he uses following such an obsession, that is checking arousal levels, self reassurance, and so on. Throughout the course of treatment, patients are asked to engage in increasingly more challenging exposure tasks while continuing to refrain from the use of rituals and avoidance to decrease anxiety and distress.

2 Case Presentation

The patient was fully consented as to the content of this manuscript. To maintain confidentiality, all demographic information was altered.

“Simon” (not his actual name) is a 51-year-old, White male who works in finance in middle management. He graduated from college with a 4-year degree and obtained a master’s degree from a state university prior to entering the finance industry. He is married with two children and identifies his religious affiliation as Catholic.

3 Presenting Complaints

During his initial evaluation, Simon described frequent fears that he might be “gay” despite a lack of physical attraction to other men. Many of these fears involved the concern about what might happen if he were gay, including having to leave his wife and children, concern about being ostracized by his family and friends, and fear of enjoying a sexual relationship with another man. Simon also described significant concern related to the fear that he had been gay all along and did not know it, thus perhaps had been lying to himself about his true sexuality. In addition, he indicated that he was occasionally distressed by fears that he might do something sexually inappropriate, like grabbing another man’s rear at work. Simon reported feeling significant distress when these thoughts occurred and stated that these thoughts occupied several hours per day.

Initially, Simon had some difficulty identifying the compulsions that resulted following his obsessions. He indicated that he maintained physical distance from other men. If another man walked into a room, particularly in his office at work, he would place his hands behind his head in an effort to avoid touching them. He also sought reassurance from his father and mental health professionals about his sexuality. In addition to these compulsions, Simon reported that he was engaging in a great deal of avoidance behaviors in an attempt to minimize number of obsessions he was having as well as the distress he felt around other men. He was avoiding many activities including his children’s sporting events, one-on-one meetings at work with males, and movies or television shows featuring masculine characters. Because of the extent of his avoidance, Simon’s initial OCD severity score (based on the Yale-Brown Obsessive-Compulsive Scale [YBOCS]; Goodman et al., 1989), which fell in the moderate range, may be a low estimate of the actual severity of his symptoms.

Simon’s obsessions related to sexuality were causing him a considerable amount of distress and were affecting his quality of life across several domains. Most notably, his relationship with his wife was suffering. This included a decrease in sexual activities, due to the fear that he would have obsessions during sex, and poor communication. In addition, he reported avoiding social

interactions due to the discomfort of being around other men, which extended to activities with his family outside the home. Because of this extensive avoidance, Simon's pleasurable activities were severely limited and he was experiencing significant symptoms of depression in addition to the symptoms associated with his OCD.

At the time of his intake, Simon's depressive symptoms included sadness, loss of interest in activities, fatigue, loss of libido, and passive suicidal ideation. He stated that decrease in libido coincided with initiation of a selective serotonin reuptake inhibitor antidepressant (SSRI). By the time Simon started EX/RP therapy and began eliminating avoidance, he was indicating a significant increase in depressive symptoms, including feelings of guilt, decrease in pleasurable activities, tension, irritability, psychomotor retardation, fatigue, weight loss, and passive suicidal ideation. Simon also described periods of crying between sessions and significant depressive rumination. He reported at intake that he experienced some social anxiety specifically related to public speaking.

4 History

Simon stated that he started having worries about being gay at age 12. He also reported that he had experienced some obsessions related to the fear of harming himself or others in the past, but this was not a current concern for him. In college, Simon saw a psychologist periodically for supportive therapy. He continued to see this particular clinician for 10 years but was never diagnosed with OCD. After that initial therapist, he was seen by several other clinicians for brief periods of time. Four years prior to coming to treatment at this time, he was examined for 1 year by a psychologist who treated him using exposure techniques for OCD. Simon described this treatment was somewhat helpful but with very difficult homework, which ultimately resulted in his leaving the treatment before its completion. In addition, Simon had tried an SSRI at that time with minimal symptom reduction and significant side effects.

Simon described growing up in a large family of four children with one brother and two sisters. He described a distant relationship with his brother because of distress related to his brother's sexual orientation. Simon described a similarly distant relationship with his mother whom he portrayed as very anxious. He did indicate that he had a close relationship with his father and stated that they spoke nearly every day.

5 Assessment

Included in the EX/RP treatment protocol is a strong emphasis on understanding not just the obsessions and compulsions but also both internal and external stimuli that trigger intrusive thoughts, images, and impulses. This thorough assessment is considered an important step in understanding the individual's case formulation. Because each individual's OCD is very different, understanding both the symptoms and avoidance strategies is essential to inform the treatment plan. During the first two EX/RP sessions, Simon was evaluated to help determine what his particular triggers were along with any avoidance strategies he was using.

Simon was asked to describe situations in which he experienced intrusive thoughts about being gay. He described having these distressing thoughts when he saw what he considered to be a masculine looking man or images in magazines or on television representing masculinity. He also reported that seeing two men talking to each other could trigger thoughts about possibly being gay. In addition, Simon described sexual side effects related to his SSRI and reported that the loss of sexual interest in his wife would also trigger his concerns about being gay.

To monitor his progress throughout treatment, Simon was given several assessment measures on a monthly basis. These assessments included both self-report questionnaires and clinician-administered symptom assessments. The following assessments were used throughout Simon's treatment.

YBOCS. The YBOCS (Goodman et al., 1989) is a clinician-administered, semistructured interview used to assess both the presence and severity of both obsessions and compulsions. The YBOCS has been shown to have good reliability and validity.

Hamilton Depression Scale (HAM-D). The HAM-D (Hamilton, 1960) is a clinician-administered interview designed to assess current symptoms of depression. It has been found to be highly reliable and sensitive to changes in severity throughout treatment (Dozois & Dobson, 2002).

Brown Assessment of Beliefs Scale (BABS). The BABS (Eisen et al., 1998; Eisen et al., 2001) is a semistructured interview consisting of seven items all rated on a Likert-type scale. This scale is designed to measure the level of insight the patient has into the obsessional beliefs they are experiencing. The BABS has been found to have excellent interrater reliability and test-retest reliability as well as a high level of internal validity.

Obsessive Compulsive Inventory-Revised (OCI-R). The OCI-R (Foa et al., 2002) is a self-report questionnaire designed to assess the presence of various symptoms of OCD. It consists of a total score as well as several subscales. This measure has been found to have good reliability and validity.

Quality of Life Satisfaction Questionnaire (Q-LES-Q). This (Endicott, Nee, Harrison, & Blumenthal, 1993) self-report measure is designed to assess satisfaction of the patient across multiple domains of functioning over the past week. This measure has been found to be both reliable and valid while reflecting changes following treatment (Kocsis et al., 1997).

Social Adjustment Scale-Self Report (SAS-SR). The SAS-SR (Weissman & Bothwell, 1976) is a self-report measure designed to measure functional impairment in a variety of psychiatric populations. Fifty-four items measure functioning across multiple domains including social interactions and work functioning.

6 Case Conceptualization

Simon's symptoms can be best understood with a cognitive-behavioral conceptualization of OCD. The intrusive, distressing thoughts Simon experienced are similar to those experienced by a large majority of the general population (Rachman & de Silva, 1978). Thus, it was not the thoughts themselves but Simon's response to them that was creating his difficulties. In Simon's particular case, he experienced frequent intrusive thoughts about possibly being gay. Simon interpreted these thoughts as significantly distressing and made efforts to avoid thinking similar thoughts in the future. These avoidance strategies included avoidance of "sporty" men or media representations of "masculine" men. In addition, he avoided being in confined areas with other men. When forced to be in such situations, he would create physical distance between himself and the other man. These avoidance strategies served to decrease the anxiety Simon was experiencing in the short term. By removing himself from stimuli that prompted the intrusive thoughts, he was able to decrease the frequency of the thoughts. However, despite his attempts at avoidance, he was unable to completely avoid intrusive thoughts, and their continued presence caused him increased distress over time. In addition, Simon's avoidance eliminated many social and family activities from his life and caused him difficulties in his job. Increased social isolation and job stress contributed to both his symptoms of depression and his continued belief that intrusive thoughts were highly problematic. Avoidance of the thoughts also served to reinforce the idea that the thoughts were indeed threatening by proving that if he avoided the feared stimuli (i.e., other men) that nothing

bad (i.e., participating in sexual activity with another man) would happen. Because his strategy of avoidance worked temporarily reducing anxiety, Simon saw avoidance as a necessary strategy. Thus, in the future when an intrusive thought about being gay occurred, Simon avoided other men or created physical distance when total avoidance was not possible. In this way, Simon continued the cycle of intrusive thought, avoidance, and temporary relief from anxiety.

7 Course of Treatment and Assessment of Progress

Simon came to the center as part of a larger research study examining the augmentation of SSRI treatment for OCD with either EX/RP, risperidone, or pill placebo. Assessments were conducted by master's or doctoral-level independent evaluators, including the second author, at regular intervals before, during, and after treatment, which was every 4 weeks up to week 32. All evaluators were blind to the patient's treatment condition.

At his initial baseline evaluation, Simon had a score of 24 on the YBOCS, which is above the clinical cutoff for study inclusion. At that point, Simon was taking 60 mg of citalopram as an antiobsessional and 0.5 mg of lorazepam as needed, used infrequently for anxiety. Because Simon had only partially responded to this regimen, this was augmented with risperidone to enhance the effect of the SSRI, titrated up to 2.5 mg per day. He was able to consistently take these medications as prescribed on a daily basis. He initially showed some improvement following the addition of risperidone but had significant side effects, including musculoskeletal rigidity, weight gain, and decreased libido. Because of these side effects, risperidone was discontinued at week 8, citalopram was increased to 80 mg at week 12, and Simon assigned to a clinician to receive EX/RP therapy starting at week 16. He was maintained on 80 mg of citalopram and 0.5 mg of lorazepam as needed throughout his time in psychotherapy. His YBOCS score at week 12 was a 9, which is in the borderline range and is indicative of his improvements while on the risperidone. Following his discontinuation of risperidone, his YBOCS increased prior to the initiation of exposure session in EX/RP therapy.

Sessions 1 to 2

The first two sessions were devoted to assessment of symptoms and current functioning along with in-depth psychoeducation about OCD and the rationale for EX/RP treatment. Simon's EX/RP therapy was provided by the first author. Psychoeducation specific to Simon's symptoms included information about normal patterns of sexual arousal, including the fact that heterosexual people may occasionally feel attracted to people of the same sex and may find these thoughts pleasant or unpleasant (Renaud & Byers, 1999). During these initial sessions, the therapist instructed Simon in completing self-monitoring forms to track his rituals throughout the day. Between Sessions 1 and 2, the patient only completed 2 days of monitoring. Importance of daily monitoring was addressed again during the second session to help the patient understand that the monitoring is vital in the treatment planning process. In addition, in the second session, a preliminary hierarchy was created using some of the internal, external, and avoidance cue. Table 1 lists the final items in the hierarchy, and during treatment session the item was practiced and/or assigned as homework.

Session 3

Starting in Session 3, exposure exercises either imaginal or in vivo were conducted in session and assigned between sessions for continued practice. Imaginal exposures were used when in vivo exposures were not possible. In the case of Simon, imaginal exposure focused on all the things that would be bad if he were in fact homosexual. In vivo exposure focused on creating physical

Table 1. Scores on Outcome Measures by Treatment Phase

	Baseline	SSRI augmented with risperidone				EX/RP: Session 3, Session 7.5, Session 12			Post EX/RP	6 week follow-up
Tx week	0	4	8	12	16	20	24	28	32	
YBOCS	24	14	9	14	22	3	5	3	4	
OCI-R	8	12	7	11	13	3	6	2	3	
BABS	14	11	4	10	7	3	2	0	0	
HAM-D	9	5	16	14	14	1	1	1	0	
Q-LES-Q	54	54	38	41	54	71	73	70	71	
SAS-SR	2.05	1.81	2.79	2.45	2.50	2.05	1.71	1.67	1.50	

Note: SSRI = serotonin reuptake inhibitor antidepressant; EX/RP = exposure and ritual prevention; YBOCS = Yale-Brown Obsessive Compulsive Scale; OCI-R = Obsessive Compulsive Inventory-Revised; BABS = Brown Assessment of Beliefs Scale; HAM-D = Hamilton Depression Scale; Q-LES-Q = Quality of Life Satisfaction Questionnaire; SAS-SR = Social Adjustment Scale-Self Report. All assessments were conducted by independent evaluators who were blind to the patient's treatment condition. The baseline evaluation was conducted prior to medication or psychotherapeutic treatment but after a stable period of SSRI use. Two YBOCS assessments were conducted at baseline (one by a psychologist and one by a trainee), and the score from the senior evaluator is shown. EX/RP therapy started at week 16 with the first therapist and then switched to the second therapist at week 20. Week 28 assessment was conducted shortly after the completion of EX/RP therapy.

proximity to other men and contact with materials related to homosexuality (e.g., magazines, movies, etc.).

In Simon's third session, the therapist reviewed his self-monitoring of rituals. The majority of situations that triggered obsessions for Simon were times he was in close physical proximity to other men. The fear hierarchy was refined during this session as well. Following the completion of the fear hierarchy, an initial in vivo exposure was started. During the session, Simon had a conversation about gay marriage legislation with another man while his therapist periodically recorded his rating of distress. Distress was rated using the Subjective Units of Distress/Discomfort Scale (SUDS), with 100 being the highest level of distress possible and zero being perfectly relaxed. During this 20-min exposure, Simon's SUDS (0-100) peaked at 20 and dropped off to 5 by the end of the exercise. Following successful completion of the in-session exposure exercise, the therapist discussed with Simon the daily between-session exposure he would need to complete. Simon was instructed to continue monitoring his rituals and to draft an imaginal exposure script outlining his fears about being gay. In addition, Simon was instructed to initiate one-on-one conversations with other men during the week.

Session 4

Simon did not complete any of his ritual monitoring prior to his fourth session but did engage in some of the in vivo exposure exercises between sessions. Simon was also able to engage in one-on-one conversations with other men and record his SUDS during the activity. He also drafted an imaginal exposure script that he then read aloud in session. Simon reported significant feelings of depression during and following his imaginal exposure exercise at home. He indicated that he experienced some physiological arousal related to the story, which made him feel depressed. Psychoeducation about physiological arousal was provided to help the patient understand some of the misinterpretation of physiological cues that contribute to and maintain some of the OCD thoughts. He was informed that being physiologically aroused by a stimulus is not the same as wanting that stimulus. For homework, Simon was instructed to listen to the recording of the imaginal exposure script, continue recording rituals, watch a movie with a gay theme, and to locate men's magazines to bring to the following session.

Table 2. Exposure Hierarchy With SUDS by Treatment Session

Exposure	Initial SUDS	Treatment session
Looking at men's pictures in magazines (e.g. <i>Men's Health</i> , <i>GQ</i>)	25	4, 5, 6
Compliment a man on his appearance	30	4
Watch movie, the gay-themed movie <i>Milk</i>	30	4, 5
Watch unfamiliar TV shows (e.g., baseball, news)	35	3
Conversation with another man about gay issues	40	3
Imaginal exposure about sexual encounter with another male	45	3, 4, 5
Imaginal exposure about consequence of being gay and no good	45	6-9, 11, 15
Watch the gay-themed movie <i>Brokeback Mountain</i>	45	7, 8
Be alone with another man and converse	50	3
Stand too close to another man and have a conversation	55	8, 12
Read gay literature from Internet	60	7
Have a beer alone and talk to another man at bar	60	11, 12, 15
Talk with an attractive "masculine" man	60	12, 13
Talk to coaches of daughter's softball team	65	13
Collect gay newspapers and read them/look at gay images	70	7, 8, 9
Go to a gay reading room/bookstore and read a book	80	7
Talk to brother about his experience being gay	80	16
Watch gay pornography	85	10-17
Go to a gay bar	100	14, 15

Note: SUDS = Subjective Units of Distress/Discomfort Scale

Session 5

Simon's homework was reviewed at the beginning of his fifth treatment session. He completed both his ritual monitoring forms and his exposure exercises. Simon listened to the imaginal exposure six times during the week and experienced a drop in his SUDS. He also watched the homosexual-themed movie *Milk* in its entirety. However, Simon reported flipping through the men's magazines rather than staring at a single image, which was not resulting in the habituation needed for the exposure to be effective. Therefore, during the session, Simon stared at one image at a time for a prolonged period of time with his therapist and recorded his SUDS. During this exposure, Simon's SUDS peaked at 30 and remained at 25 even after the exposure had ended. For homework, Simon was instructed to continue looking at a single image in the magazines, listening to the imaginal exposure, and recording rituals, and to rewatch the most distressing scenes from the movie *Milk*.

Session 6

Prior to Simon's sixth session, he listened to the imaginal exposure several times, watched the movie *Milk*, and looked at pictures in men's magazines. Simon reported significant anxiety while watching the movie as indicated by a SUDS level of 60. Simon continued to report significant feelings of depression during completion of his homework. He was able to identify the belief that if he were gay, he would be "no good." Simon was instructed to draft a new imaginal exposure outlining what it was about being gay that would make him "no good." For homework, Simon was also instructed to continue looking at men's magazines, listening to the new imaginal exposure tape, and watching most distressing scenes from *Milk*. In response to obsessions that Simon might experience on a daily basis, he was instructed to mentally "agree" with the thoughts. For example,

if he had the thought “What if I am really gay?” then rather than engage in mental reassurance, he was to mentally respond with, “Yes, I am just gay, and that makes me no good.”

Session 7

Simon reported that he was able to listen to his imaginal exposure, and he created a new one prior to the next session. He also watched distressing scenes from the movie and looked at men’s magazine pictures. During the session, Simon read the new imaginal exposure and worked with the therapist to add more detailed information about all the bad things he believed would happen if he was gay. He then made an audio recording of the new imaginal exposure to listen at home. Simon also did an in vivo exposure involving reading information he found online related to the experience of being gay. For homework, Simon was assigned to listen to the new recording, rent and watch a new movie with homosexual themes, visit a gay bookstore or reading room, and purchase some gay-themed magazines.

Session 8

Following Session 7, Simon’s therapist had an unexpected medical leave and a new therapist, the third author, was assigned to complete Simon’s treatment. Prior to the eighth session, Simon repeatedly listened to his imaginal exposure, watched the homosexual-themed movie *Brokeback Mountain*, and stared at pictures in gay men’s magazines. As this was his first meeting with his new therapist, a large portion of the session was spent getting acquainted. An in vivo exposure was also conducted using the magazine pictures. Simon was instructed to continue listening to the imaginal exposure, watching movie scenes, and staring at men’s pictures in the gay magazines.

Session 9

Prior to his ninth treatment session, Simon again watched *Brokeback Mountain*, listened to the imaginal exposure, and sat in close physical proximity to other men for homework. During the session, Simon and his therapist stared at a picture of men engaging in sexual activity with other men. Simon’s SUDS peaked at 40 while staring at this picture, which was significantly lower than he expected. By the end of the session, his SUDS had dropped to 30. Simon was instructed to continue listening to his imaginal exposure and to look at the picture from the session at home before his next session.

Sessions 10 to 17

Simon continued listening to his imaginal exposure between sessions. He also made an effort to be in close physical proximity to other men and to engage in one-on-one conversations with men at work and at his children’s athletic events. Starting in his 10th therapy session, Simon watched sections of homosexual pornography with his therapist. The therapist reminded Simon that it was normal to feel a certain amount of sexual arousal while watching sexual activities, even though in this case the activities only involved men. During the exposure, Simon’s SUDS peaked at 40, which was again lower than he expected. This exposure was repeated in all the following treatment sessions to ensure habituation. Simon was instructed to watch segments of the pornographic DVD at home between sessions. He was also asked to engage in normal activities he had been avoiding, such as having sex with his wife and talking with other men at a sports bar. At the top of the hierarchy, Simon and his therapist went together to a gay bar as an in-session exposure. While at the gay bar,

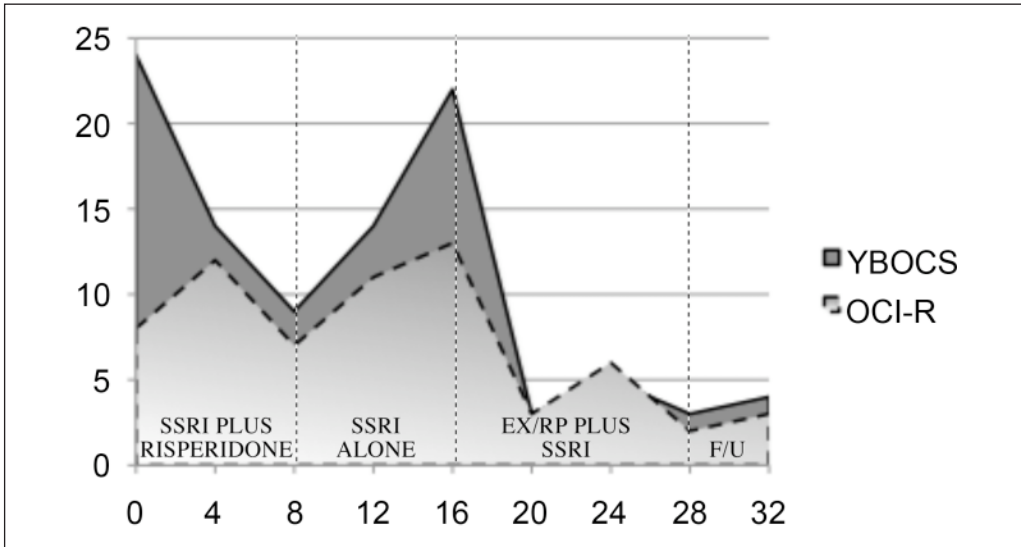


Figure 1. Changes in symptoms over time weeks in treatment

Note: YBOCS = Yale-Brown Obsessive Compulsive Scale; OCI-R = Obsessive Compulsive Inventory-Revised; SSRI = selective serotonin reuptake inhibitor antidepressant; EX/RP = exposure and ritual prevention; F/U = Follow-Up period.

Simon's SUDS peaked at 25 and dropped to 15 by the end of the exposure. By the final session, Simon reported a peak SUDS level of 5 while watching homosexual pornography.

Toward the end of treatment, discharge planning became a focus during therapy sessions. Discharge planning largely involved the discussion about relapse prevention, progress made in therapy, and developing a plan in the event of symptom reoccurrence. Simon's discussion of relapse prevention with his therapist focused on continued naturalistic exposures, "spoiling" rituals when they happen, and calling his therapist with any questions or concerns that might arise in the future.

Outcome Evaluation

By the end of treatment, Simon reported that he was no longer bothered by his obsessive-compulsive symptoms. His symptoms were evaluated 12 days after his last treatment session for his post-treatment assessment. Self-report and clinician-administered measures of OCD all indicated substantial decreases in symptom severity. His score on the YBOCS fell from 24 at intake to 3, an indication of minimal symptoms. Similarly, his score on the OCI-R fell from 8 at baseline to 2. On the BABS, he endorsed the belief that "if I have thoughts of being gay, I would be really uncomfortable and worthless," which fell from a score of 14 to 0. His depressive symptoms that peaked during his risperidone treatment at 16 fell to 1 after treatment. His quality of life improved from a Q-LES-Q score of 54 to a 70 at follow-up. The SAS-SR measure of social adjustment difficulty decreased from 2.05 to 1.67. Interestingly, all of Simon's improvements occurred quite abruptly from the early stage of treatment to the first midtreatment assessment. Table 1 presents his progress on all measures. Figure 1 illustrates the decrease in OCD severity based on the YBOCS and OCI-R scores.

The EX/RP therapy was clearly effective in ameliorating Simon's symptoms of OCD. His decrease in depressive symptoms could have been due to the improvement in his OCD symptoms, the direct result of the behavioral activation implemented early in treatment, or a combination of the two.

8 Complicating Factors

As with most treatment options, there were some challenges throughout the course of treatment. Simon appeared to understand both the cognitive behavioral model for OCD and the treatment rationale for EX/RP therapy. Initially, he was having some difficulty following through with homework assignments, particularly self-monitoring and imaginal exposure exercises. His depression was interfering with his ability to work on the imaginal exposures because of an increase in depressive symptoms following the exercise. The imaginal exposure focused on a detailed sexual encounter with a man, which resulted in physiological arousal that increased depressive rumination and obsessive thoughts. This was addressed in session by explaining that exposure exercises were intended to increase anxiety but not depression. Simon was asked to draft another imaginal exposure that focused more on his perceived negative consequences of being gay rather than the physical relationship he would have with another man. Simon was also offered additional between session contacts with the therapist if he found that his depressive thoughts were increasing significantly.

Another significant problem that occurred in treatment was the unplanned switch in therapist midway through treatment. This transfer was due to an unexpected medical leave of the first clinician. This switch resulted in a significant delay between sessions. In addition to the delay, Session 8 was primarily to allow the new clinician to become acquainted with the patient and treatment thus far. Although this somewhat slowed down the progression of treatment, it did not result in a regression to previous symptoms or any other significant distress to the patient. This was likely due in part to the fact that the client continued to engage in daily homework exercises during the break in treatment.

9 Follow-Up

At the end of treatment, the patient was offered the opportunity to call his therapist or to schedule a booster session if he experienced any difficulties following termination. At the time of termination, his YBOCS total score was 3, which falls within the normal range, indicating that Simon was no longer experiencing any significant symptoms of OCD. At the 6-week follow-up assessment, his YBOCS score remained in the normal range indicating that not only had he significantly improved but also that he maintained his gains in the 6-week period following termination of treatment. His 6-week follow-up scores on all measures are shown in Table 1. Three months after the conclusion of treatment, he was contacted by his first therapist by phone for a follow-up report and reported no difficulties. To date, Simon has not requested a booster session.

10 Treatment Implications of the Case

Because of the sensitive nature of unwanted sexual thoughts, stigma surrounding homosexuality, and great potential for misdiagnosis, it is critically important that sexual-orientation symptoms in OCD be readily identified and well understood by clinicians (Williams, 2008). To date, very little information about the prevalence, correlates, or treatment of sexual-orientation obsessions and related compulsions has been published. Sexual-orientation obsessions are distressing to those experiencing them and often misunderstood by clinicians treating them. More research is needed to raise awareness about this particular symptom of OCD. However, at this time, it appears that EX/RP therapy is effective in the treatment of this OCD presentation, despite being understudied.

11 Recommendations to Clinicians and Students

The success of EX/RP therapy in this case suggests that sexual obsessions in OCD are not different from other types of OCD except in the specific content. The primary reason for bringing

special attention to this particular form of obsessions is the common misdiagnosis or lack of diagnosis in those patients with sexual-orientation obsessions. Individuals presenting for treatment with OCD should be asked about sexual content in the same way they are asked about other types of obsessions.

It is important to differentiate those with intrusive unwanted sexual obsessions from those who may be experiencing distress related to dissatisfaction about their actual sexual orientation, as EX/RP therapy is not supported or validated as a means of sexual-orientation reassignment. Sexual-orientation obsessions can be differentiated from true sexual-orientation concerns in the type of distress they produce. Sexual obsessions are ego-dystonic and are experienced as unwanted, intrusive thoughts. For someone identifying as homosexual, this would likely not be the case. Sexual thoughts about same-sex partners would be considered pleasurable rather than simply distressing, though such patients may also feel guilt and discomfort about having enjoyable same-sex thoughts. It is possible in some cases that patients may be distressed because they are actually gay or bisexual and also have OCD. Therapists are urged to use caution and sensitivity to explore this possibility, as most OCD patients with sexual-orientation obsessions are not gay and questioning them in this manner can increase distress and damage rapport (Williams, 2008).

For those patients presenting with sexual obsessions in OCD, EX/RP therapy continues to be an effective treatment. Sexual-orientation fears would be considered part of the symptom dimension sometimes called “unacceptable thoughts,” “taboo thoughts,” or “pure obsessional.” These types of obsessions tend to be coupled with covert compulsions, such as mental rituals, checking arousal levels, and reassurance seeking (e.g., Abramowitz et al., 2003). Therefore, like in the case of Simon, extensive probing may be necessary to uncover all rituals and avoidances. In addition, imaginal exposure will likely be an important component to treatment. Other than the specific items on the treatment hierarchy, we believe there are likely to be no differences between the necessary treatment approach for this presentation of OCD and any others. It is expected that individual hierarchy items vary from patient to patient. Exposures can be designed to target the fears present in sexual-orientation obsessions just as effectively as with any other form of OCD, so clinicians should aggressively treat this symptom presentation without hesitation.

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