



## Sexual orientation obsessions in obsessive–compulsive disorder: Prevalence and correlates

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### ABSTRACT

Sexual obsessions are a common symptom of obsessive–compulsive disorder (OCD) that may be particularly troubling to patients. However, little research has examined concerns surrounding sexual orientation, which includes obsessive doubt about one's sexual orientation, fears of becoming homosexual, or fears that others might think one is homosexual. The present study reports rates and related characteristics of individuals with sexual orientation obsessions in a clinical sample. Participants from the DSM-IV Field Trial ( $n = 409$ ; Foa et al., 1995) were assessed with the Yale–Brown Obsessive Compulsive Symptom Checklist and Severity Scale (YBOCS). We found that 8% ( $n = 33$ ) reported current sexual orientation obsessions and 11.9% ( $n = 49$ ) endorsed lifetime symptoms. Patients with a history of sexual orientation obsessions were twice as likely to be male than female, with moderate OCD severity. Time, interference, and distress items from the YBOCS obsessions subscale were significantly and positively correlated with a history of obsessions about sexual orientation. Avoidance was positively correlated at a trend level ( $p = 0.055$ ). Obsessions about sexual orientation may be associated with increased distress, interference, and avoidance, which may have unique clinical implications. Considerations for diagnosis and treatment are discussed.

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### 1. Introduction

Obsessive–compulsive disorder (OCD) is an extremely disabling and distressing anxiety disorder, with nearly two-thirds (65.3%) reporting severe impairment (Ruscio et al., 2010). Lifetime prevalence rates are estimated at 1.6% to 2.3% (Kessler et al., 2005; Ruscio et al., 2010), while current (12-month) rates range from 0.6% to 1.3% (Crino et al., 2005; Ruscio et al., 2010). Obsessions are defined by the DSM-IV-TR as intrusive, unwanted thoughts, images, or impulses that increase anxiety; compulsions are defined as repetitive physical or mental acts used to decrease anxiety (APA, 2004). The National Comorbidity Survey Replication (NCS-R) estimates the onset of OCD to be on average 19.5 years, with the odds of onset significantly higher among females than males (Ruscio et al., 2010). Effective treatments for OCD include pharmacotherapy and exposure and ritual prevention (EX/RP), a type of cognitive behavioral therapy (NICE, 2006).

Typical manifestations of OCD include contamination/washing, doubt/checking, ordering/arranging, unacceptable/taboo thoughts, and hoarding symptoms (Abramowitz et al., 2003; Pinto et al., 2008). Factor analyses have found sexual obsessions to consistently load highly onto the “unacceptable/taboo thoughts” category (Pinto et al., 2007) and may include unwanted sexual thoughts about family or children, fears about engaging in sexually aggressive behavior, or

concerns about sexual orientation. Sexual obsessions are not uncommon in OCD. In the NCS-R study, 30.2% of people with OCD reported sexual and/or religious obsessions (Ruscio et al., 2010), although it is not known exactly how many of these experienced sexual obsessions since the two categories were combined.

Grant et al. (2006) studied sexual symptoms in OCD patients. In their treatment-seeking sample of 296 adults, they found current sexual obsessions among 13.3%, with 24.9% reporting symptoms in the past. Patients with sexual obsessions were on average 38.2 years of age, and 53.8% were female, which was not significantly different from patients without sexual symptoms. About 82.1% had a comorbid Axis I diagnosis, and 20.5% were disabled due to their OCD symptoms. Both patients with and without sexual symptoms had a moderate level OCD severity on the Yale–Brown Obsession Compulsive Disorder Scale (YBOCS; Goodman et al., 1989), however those with sexual symptoms had slightly higher scores. There were no differences between groups in amount of insight into OCD symptoms as measured by the Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998).

Sexual orientation concerns fall within the larger category of sexual obsessions and have been the subject of little research. Sexual orientation obsessions include recurrent doubts about whether one is gay or straight, fears of becoming homosexual, or fears that others might think one is homosexual (Williams, 2008). A person may have only one of these concerns or a combination. For example, Williams (2008) provides the following narrative as an example of the type of intrusive thoughts and ruminations a patient with obsessions about

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sexual orientation might experience: “How can I be attracted to men if I have always loved women? I have dated many women before and never thought about a relationship with a man. Thinking about doing sexual acts with a member of the same sex repulses me. I can't possibly be gay. But why I am thinking of men all the time now? That must mean I am gay.” Sexual orientation concerns are addressed on the YBOCS checklist by a single item that asks if obsessional “content involves homosexuality.” In a factor analytic study of the YBOCS checklist, Pinto et al. (2008) note that 9.9% of their sample ( $n = 485$ ) endorsed past or present obsessions related to homosexuality, using data from the OCD Collaborative Genetics Study (OCGS; Samuels et al., 2006). However, no additional information about this subgroup has been reported.

OCD is one of the most complex mental illnesses, and, due to the varied symptoms of the disorder, an OCD diagnosis can be easily missed (Bystritsky, 2004; Sussman, 2003). Making improvements to the assessment and diagnosis of OCD remains an important area of focus for research and clinical practice (Grabill et al., 2008). Although sexual orientation obsessions appear to be relatively common among people with OCD, this symptom is often misunderstood by clinicians and by patients. A mental health professional may misinterpret the obsessions as fantasies or wishes. The patient may be misdiagnosed as experiencing anxiety or depression as a result of a sexual identity conflict (i.e., distress over “coming out the closet.”) Obsessions or mental compulsions may be mistaken for depressive ruminations. Such misconceptions can result in errors in treatment. For example, Williams (2008) describes an individual with obsessions about sexual orientation where the therapist made the focus of treatment the patient's sexual activities rather than implementing EX/RP. This resulted in an increase of symptoms and suicidal ideation, which illustrates the serious nature of the disorder and potential for harm if not properly treated. As another example of confusion surrounding this issue, a committee in Sweden determined that the YBOCS checklist item assessing homosexual thoughts should be discontinued because there was no corresponding “heterosexual thoughts” item (Ruck and Bergstrom, 2006). Ruck and Bergstrom note that the committee did not understand that the YBOCS does not assess sexual orientation, rather unwanted obsessions related to sexual orientation within OCD.

People with and without OCD have unwanted homosexual thoughts. Renaud and Byers (1999) found that among a sample of college students ( $n = 292$ ), both men and women reported having sexual thoughts about “engaging in sexual activity contrary to [their] sexual orientation,” with 50% of males and 43% of females classifying this a negative thought. Most people with unwanted thoughts are able to dismiss them, however people with OCD tend to have cognitive biases in favor of the over-importance and need for control of intrusive thoughts; they tend to believe that the mere presence of a thought indicates that the thought is highly meaningful in some way (OCCWG, 2003). Thus people with OCD feel greater distress about unacceptable thoughts.

Because the sensitive nature of unwanted sexual thoughts and the great potential for misdiagnosis, it is critically important that all symptoms of OCD be readily identified and well-understood by clinicians to aid in improved diagnosis and treatment. To date, little data has been presented on the prevalence of obsessions about sexual orientation in OCD or correlates of these symptoms. In this investigation, we report rates about sexual orientation obsessions in a large sample of OCD patients by revisiting data from the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) Field Trial (Foa et al., 1995). We examine correlating characteristics including gender, age, OCD severity, avoidance, and insight. Based on previous findings by Grant et al. (2006), we hypothesize that patients with a history of sexual orientation obsessions experience more severe OCD symptoms and avoidance than those without a history of these obsessions. Further, we hypothesize that gender and level of insight will be comparable between the groups.

## 2. Method

### 2.1. Participants

Participants ( $n = 431$ ) were treatment-seeking adults recruited from five different OCD specialty clinics (Medical College of Pennsylvania, Yale University, Columbia University, Massachusetts General Hospital, and Brown University) and two additional centers (Clarke Institute and Emory University). Data on OCD severity were missing for some patients, therefore a final sample of 409 was used. Patients were excluded if other diagnoses were primary (e.g., substance use/dependence), or if English was not spoken. Further details about the larger sample can be found in Foa et al. (1995).

### 2.2. Measures

Patients were initially screened over the telephone, and if deemed appropriate (i.e., a probable diagnosis of OCD), were scheduled for a structured clinical diagnostic assessment with an evaluator familiar with OCD.

The YBOCS was administered to all participants to assess symptoms of OCD. The YBOCS is a clinician-administered measure that consists of an extensive 60-item symptom checklist and 10-item severity scale, along with nine supplementary questions that assess related symptoms (Goodman et al., 1989). The symptom checklist categorizes obsessions and compulsions into subgroups. The obsession subgroups include: aggressive, contamination, sexual, religious/scrupulosity, symmetry/exactness, hoarding, somatic, and miscellaneous concerns. Symptoms are coded as having never been a problem, occurring in the past only, or currently present (past week). The severity scale is similarly divided into the obsessions subscale (five questions) and the compulsions subscale (five questions), followed by supplementary items that do not contribute to the total severity scale score. YBOCS severity scale scores  $\leq 16$  are considered sub-clinical, and a score  $\geq 26$  is considered severe. Two of the additional items (numbers 11 and 12) were used to measure level of insight and avoidance into OCD symptoms. All items on the YBOCS severity scale are scored from 0 to 4, with higher scores indicating increased severity.

## 3. Results

Current and past sexual obsessions were reported by 16.8% ( $n = 69$ ) and 9.5% ( $n = 39$ ) respectively. Patients with obsessions about sexual orientation or homosexuality were a subset of those with general sexual obsessions. Eight percent ( $n = 33$ ) of the sample reported current obsessions about sexual orientation, and 3.9% ( $n = 16$ ) endorsed past symptoms, thus a total of 11.9% ( $n = 49$ ) of patients endorsed lifetime symptoms. Significance tests (t-tests and chi-squares) were completed to determine if characteristics were associated with lifetime versus no history of obsessions about sexual orientation. Results are presented in Table 1.

Internal consistency of the YBOCS Severity Scale (10 items) was found to be excellent (Cronbach's  $\alpha = 0.92$ ). Individuals with a lifetime history of obsessions about sexual orientation (current or past) had moderate OCD severity on the YBOCS, and were twice as likely to be male than female ( $p = 0.048$ ). Three of the items on the obsession subscale of the YBOCS (time, interference, and distress) were found to be significantly and positively correlated with obsessions about sexual orientation, such that these patients reported significantly more time on an average day being occupied by obsessive thoughts ( $p = 0.031$ ), more interference from obsessions ( $p = 0.007$ ), and more distress from obsessions ( $p = 0.001$ ). Patients on average had good to excellent insight (YBOCS item 11), which was not significantly different from others with OCD, though there was a trend toward greater avoidance due to OCD symptoms (YBOCS item 12;  $p = 0.055$ ).

Because we examined lifetime symptoms, sexual orientation obsessions could have occurred at any age. Thus we also compared the ages of participants with past versus present sexual orientation obsessions. No significant differences were found [ $t(47) = 1.32$ ,  $p = 0.19$ ; mean age was  $36.7 \pm 14.3$  for current and  $31.6 \pm 7.7$  for past].

## 4. Discussion

To our knowledge, no large studies have specifically examined obsessions about sexual orientation within OCD. The rates of lifetime obsessions about sexual orientation in the current study mirror rates found in a research sample (Pinto et al., 2008). While Grant et al.

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