



# THE MANIFESTATION OF HOMOSEXUAL OBSESSIVE COMPULSIVE DISORDER (hOCD) AND INTERVENTION BY THE INTEGRATION OF MINDFULNESS TECHNIQUES WITH COGNITIVE BEHAVIOR THERAPY (CBT): A CASE STUDY

Anwasha Bhattacharyya<sup>1</sup>

<sup>1</sup>Assistant Professor, Clinical Psychology Centre of University of Calcutta (CPCUC), Department of Applied Psychology, University of Calcutta, Kolkata, India

## Abstract

**Objective:** The case study explored the manifestation of homosexual-obsessive compulsive disorder (hOCD) in the context of stereotypical ideas regarding sexual orientation. The aim of the study was to assess the effectiveness of an integrated approach of mindfulness and cognitive behavior therapy (CBT) in symptom alleviation.

**Method:** The manifestation of hOCD in a young Indian educated male was explored in the context of stereotypical ideas regarding sexual orientation. An integrated approach of mindfulness techniques with the cognitive behavioral framework of cognitive restructuring and exposure and response prevention (ERP) was assessed to alleviate the symptoms of the client. The effectiveness of mindfulness technique with cognitive restructuring and exposure and response prevention (ERP) in symptom alleviation was assessed by pre-post self-report measures.

**Results:** The significant stereotypical ideas contributing to the manifestation of hOCD were identified. The therapeutic intervention was found to be effective in symptom alleviation of hOCD and underlying depression.

**Conclusion:** The case study enhances the importance of stereotypical ideas in the manifestation of hOCD and also asserts the effectiveness of an integrated approach of mindfulness and CBT in symptom alleviation of hOCD as well as underlying depression.

**(Index words:** sexual orientation, stereotypical ideas, mindfulness, cognitive restructuring, exposure and response prevention)

## I. Introduction

### *Homosexual Obsession Compulsive Disorder (hOCD): Theoretical and Research Basis*

Homosexual Obsession Compulsive Disorder (hOCD) or called Sexual Orientation Obsessive Compulsive Disorder (SO-OCD) in general is a rare form of obsessive compulsive disorder which mainly involves sexual orientation themed repetitive, ruminative obsessive thoughts, obsession doubt regarding sexual orientation of the individual and may also involve compulsions such as avoidance behavior and checking rituals.

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., 2010). 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, 2011). Given these rates, it appears that such obsession 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 (Williams, 2011). The dearth of literature may be reflective of the often misunderstood nature of homosexual obsessions. 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.

A recent study reported the lifetime prevalence of OCD at 1.6% in the general population (Kessler, Berglund et al., 2005). In a large-scale study for National Anxiety Disorder Screening Day, it was found that fewer than half of the adults with OCD had ever received treatment for their disorder (Goodwin, Koenen, Hellman et al., 2002). The majority experienced significant interference in daily functioning, more than three quarters had a co-morbid depression and/or another anxiety disorder, and approximately one fourth had current thoughts of suicide.

A recent study using a broad sample of OCD patients found that 25% experienced sexual obsessions currently or in the past (Grant Pinto et al., 2006). The actual prevalence rates may be higher as people with this class of symptoms may be more reluctant to seek treatment or participate in research studies, due to embarrassment or fears they will be considered deviant.

Sexual obsessions may revolve around a multitude of loci. Common themes include unfaithfulness, incest, unusual behavior, profane thoughts combining religion and sex and homosexuality. Since, sex carries so much emotional, moral and religious importance, it easily becomes a magnet for obsessions in people predisposed to OCD (Gordon, 2002).

Homosexual anxiety has been documented in the psychological literature for decades, although descriptions and theoretical causes vary widely. "Acute homosexuality panic" was first described by Kempf in 1920 as a psychosis that resulted from the pressure of uncontrollable "sexual cravings" that occurred when men or women were grouped alone for prolonged periods (Thomas & Fremouw, 2009).

Homosexual OCD (hOCD) is characterized by obsessions like fear of becoming gay, fear of secretly being in denial regarding homosexuality, fear of being seen by others as homosexual, fear that deficits in sexual performance are a sign of changing sexual orientation and the fear that gay intrusive thoughts are going to affect heterosexual relationship and sexual performance. hOCD also include compulsions like mentally reviewing past heterosexual relationships, checking for an arousal in male company, observing people engaging in homosexual relationships, looking for reassurance for their sexual orientation from other people, avoiding people, places or situations that could trigger unwanted thoughts and trying to suppress the unwanted thoughts.

### *Manifestation of homosexual obsessive compulsive disorder (hOCD)*

The existence of the SO-OCD condition has been questioned by certain groups. For instance, the online LGBT community Empty Closets (Gomes, 2016) sees the condition as a way for heterosexual people to stay in the closet and to avoid the minority label of "homosexual." Furthermore, considering the fact that homosexuality was pathologized from the 19th century until the 1970s (Crespo, Sandra et al., 2016), it is relevant to assume that the LGBT community might perceive SO-OCD as a homophobic invention to mingle homosexuality back in psychiatric discourses.

Studies relating the manifestation of hOCD in the context of the society, culture, stigma and myths centering the theme of homosexuality are limited. However, multiple studies point out that it is not necessary that people who suffer from hOCD will be homophobic. Homosexuality anxiety is not caused by dislike of homosexuals, but rather a fear that the person will no longer have access to the opposite sex, something they highly value. They worry that the sexual life they have enjoyed or imagined with be suddenly revoked and replaced with something unappealing and foreign.

Therapists may wrongfully attribute the symptoms to an unconscious wish, latent homosexuality or sexual identity crisis. Such a misdiagnosis will only panic an already distressed individual. Conceptualizing homosexuality anxiety as a struggle with "coming out of the closet" can cause the patient to become even more upset and confused (Gordon, 2002). The key issue to understand is that the ideation is ego-dystonic or ego-alien, meaning that the hOCD obsessions are inconsistent with the individual's fundamental desires, fantasies, and sexual history.

It is interesting to note that the heterosexual identity of the individual suffering from hOCD is presumably shaped by the socio-cultural ideas, myths and beliefs regarding heterosexuality and the myths surrounding the ideas of homosexuality. Research from linguistic perspective also points out differences in male and female discursive behavior. Findings point out that men have two different ways of forming their heterosexual identities, the first based on cultural discourses of 'heterosexuality' and 'male solidarity' that maintain hegemonic masculinity. Men with these sort of sexual identity formation emphasize their heterosexuality by using swear words. There are stereotypical ideas for instance hugging other men is culturally seen as feminine. Women, on the other hand, do not spend much time negating any homosexual tendency, but rationalize their irrational thoughts in assuring themselves that straight people can think about homosexuality without turning gay. This indicates a certain fluidity in their sexuality that is absent in the narratives of men (Coimra-Gomes & Motschenbacher., 2019).

### ***Theoretical Construct of Cognitive Behavior Therapy in treating hOCD***

Cognitive-behavior therapy can be an effective way to address the distortions in thoughts associated with the disorder as well as in dealing with the compulsions. CBT has a well-documented record of efficacy for OCD (Franklin and Foa, 2011), but the treatment process can be difficult, and hOCD may offer its own difficulties.

The nature of obsessive thoughts and how the compulsions do not really help in reducing anxiety in a sustainable manner are explained in CBT. OCD is characterized by the presence of obsessions (persistent, unwanted thoughts, which intrude upon the individual's mind and produce great anxiety and doubt) and compulsions (repetitive mental or physical acts that the individual is driven to perform in order to reduce the experienced anxiety and doubt); performing the compulsion relieves anxiety for only a short time and then it returns with a higher rate of distress, which leads sufferers to perform the compulsion again (Williams, Farris et al., 2014).

Cognitive Restructuring is a CBT component that not only helps in intervening this circular pattern of irrational, anxiety provoking thought but also in replacing the irrational, false beliefs, stereotypical ideas about sexuality with rational and realistic thoughts. People with Sexual-Orientation OCD have distorted thinking about their sexuality. In Cognitive Restructuring, the objective is to learn to identify distorted thinking, and challenge it with rational, objective, evidence-base thinking. Identifying distorted thinking means learning the language of OCD and knowing when to call oneself out on maladaptive cognitions. Cognitive distortions in Homosexual OCD typically include the following:

1. All-or-nothing thinking – "If I have even a single gay thought, that must certainly mean that I am gay",
2. Catastrophizing – "Being gay would destroy my life" and
3. Discounting and minimizing the positive – "Despite having had these thoughts many times, I've always been straight, but this time is different."

Exposure and Response Prevention (ERP) is the first choice of therapeutic intervention technique in dealing with the compulsions. ERP exposes patients to situations related to their intrusive thoughts that cause them anxiety, which are often marked as triggers. The goal of this treatment is for the patient to prevent oneself from completing their compulsive behaviors when triggered by intrusive thoughts. The situations that are confronted will intensify over time, until the patient can face and overcome their most feared scenario. Once they are able to stop themselves from responding to their intrusive thoughts with compulsive behaviors, they can experience tremendous relief from the symptoms of OCD.

### ***Theoretical Construct of Mindfulness Techniques in treating hOCD***

It is well established that despite significant evidence of the effectiveness of Cognitive Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP) in the treatment of OCD, many clients fail to engage or complete treatment (Cludius et al., 2015). For example Mancebo et al. (2011) found that 25% of clients diagnosed with OCD did not engage in CBT and 30% of those who start treatment drop out. The main reason provided by clients is a fear of what CBT requires. It is important therefore to consider alternative methods to support clients to engage in interventions that are shown to be effective. Mindfulness may offer a promising option and one that has a developing literature (Hale, Strauass et al., 2013).

Mindfulness can be simply defined as “paying attention to something in a particular way, on purpose in the present moment non-judgmentally (Baer, 2003). Mindfulness is characterized by non-judgmental observation. Mind wandering is considered as simply another event to be observed in the state of non-judgmental observation of the constantly changing stream of stimuli as they arise is often called bare attention or choiceless awareness (Keng, Smoski & Robins., 2011).

The mindfulness practices are incorporated in multiple therapeutic frameworks, which include:

- Mindfulness based stress reduction therapy (MBSRT) Kabat-Zinn (1982, 1990)
- Mindfulness Based Cognitive Therapy (Segal, Williams and Teasdale, 2002)
- Dialectical Behavior Therapy (DBT) (Linehan, 1993)
- Acceptance and Commitment therapy (ACT) (Hayes, Wilson et al, 1999)

However, mindfulness as a practice could also be incorporated into daily routine activities like walking, bathing, eating or driving.

Lui, Han and Xu (2011) evaluated MBCT for six clients with OCD and found significant improvement on a range of measures. This is limited again due to the small sample size but does raise interesting questions concerning the cross cultural contribution of Mindfulness (Fairfax, 2011).

Hanstede, Gidron, Y., & Nyklíček (2008) randomly allocated 17 clients to either an eight week Mindfulness training group or a waiting list group. Their Mindfulness intervention included applying techniques of meditative breathing, body scan and mindful daily living to OCD symptoms. They reported a significant decrease in OCD symptoms in the Mindfulness group but there was no follow up and this was only compared to the waiting list group.

Meta-analyses suggest that integration of formal mindfulness training decreases distress, such as that found in OCD, across multiple mood and anxiety disorders (Chambers, Lo & Allen., 2007).

A number of commonly expressed areas in which mindfulness has helped people with OCD have been summarized below:

*Observation and non-judgment:* Exploring the association between observation and non judgment, it has been suggested that mindfulness results in perceptual change at a sensory level allowing the individual to separate the sense of self from the sensory experiences (Shonin & Gordon, 2016). It also increases the accurate identification and interpretation of mood states which in turn increases the ability to observe them without participating. Key et al., 2017 argued that the development of a nonjudgmental stance towards intrusive thoughts increases non reactivity, reduced thought suppression and avoidance, reducing reliance on neutralizing behavior (Fairfax, 2008).

*Connectedness and present moment:* The effect of being in the ‘Present Moment’ has also been related to descriptions of developing ‘stillness’ (Khanna and Greeson, 2013). Research has indicated Mindfulness can improve regulation of cardiac functioning and breathing which in turn increased psychological mindedness and insight (Telles, Raghavendra, 2013). Fairfax, Easy, Fletcher and Barfield (2014) found that in a review of their Mindfulness based treatment groups for OCD, participants reported improvements in sleep. There are therefore physiological benefits of Mindfulness that could support techniques of anxiety management and regulation of emotion in CBT (Fairfax, 2008).

*Non-reaction:* There may be two levels that Mindfulness can encourage this, firstly by making the unconscious more conscious through the development of greater awareness and secondly the deliberate resistance to usual response to stimulus. This latter process is related to the concept of ‘Urge’ Surfing put forward by Marsha Linehan (Turner, 2013) in which the individual actively decides to ‘rides the wave’ of the experience without

distraction or avoidance. In OCD urge surfing can have significant application to response prevention and relates to techniques such as the 'Five minutes Rule' (Schwartz, 2016).

*Letting Go:* Van Gordon & Shonin (2016) suggests that observation and non judgment enables an individual to become aware of the temporary nature of existence; and this encourages a more fluid attitude to internal and external events. 'Letting Go' also highlights the underlying Buddhism tradition of Mindfulness and philosophical emphasis on 'non attachment'. Encouraging a stance of 'Letting Go' through Mindfulness could support CBT and ER-P but may require a more nuanced understanding of the individual and expectations of their treatment.

## II. Case Introduction

The individual voluntarily registered himself for the therapy session. The data sources used were the detailed written case reports, the therapist notes and reflections, the therapeutic thought monitoring diary maintained by the client and the individual self-report measures. The client was enrolled with a confidentiality agreement and therapy intake form to procure consent and ensure confidentiality.

S.D is 21 year old young Indian male individual hailing from urban socio-demographic area, belonging to middle socio-economic status, a business administration graduate and was preparing for MBA entrances at the time of first visit. He is unmarried, engaged in a heterosexual relationship and belongs to a family comprising of his father, mother and a younger sister and identifies his religious affiliation as Hindu.

## III. Presenting Complaints

During the initial evaluation session, S.D reported intrusive thoughts of being gay in spite of lack of arousal towards people of the same sex and unchanged feeling of pleasure while engaging in heterosexual relationship. Since the last one year, he is having these intrusive thoughts and obsessive doubts which are also affecting his romantic relationship with his girlfriend. He feels so distressed when these doubts creep into his mind while he is with his girlfriend, that he avoids meeting her. He reported that he has also become very conscious about his own body and is vigilant towards changes in his body as per his sexuality. He had started avoiding places where he have to face or interact with a homosexual person. He avoided going to photography and art exhibitions for the past 9-10 months in spite of being deeply interested in order to avoid homosexual associations. He stated that he cannot stop himself from being vigilant and observant towards the people around him and tries to figure out by appearance, body language, gesture etc whether a person is a homosexual or not. He elaborated that on thinking or assuming that a person is homosexual he feels extremely anxious and tries his best to avoid making any eye contact or any kind of verbal exchange or interaction with the person. He stated that if the presumed homosexual person shows any interest or warmth towards him he would feel that the person is doing so because the person thinks that he is homosexual by his appearance, body language or gesture. At present, his extreme level of vigilance has got so distressing that he avoids going out unless and until it is absolutely necessary. He stated that for the past five-six months he had also been noticing that he gets irritable or agitated at the slightest of setbacks. He stated that his mood remains persistently low. His interest and motivation in earlier pleasurable activities has markedly reduced. He also feels lack of confidence.

## IV. History

The client was apparently functioning well till about two years ago. He was born into a middle class urban household. He completed his higher secondary years of formal education in a boy's school. He has recently completed his bachelor's degree in business administration from a co-educational college. As per the client, he has maintained friendship with his school friends; and is quite close to them. He has also been in a heterosexual relationship for the last three years. He has always been fond of playing cricket and has also started going to the gym on a regular basis for the past two years. The client reported that painting and photography have also been his longstanding hobby and he aspires to be a professional freelance photographer apart from being a business man someday.

The client stated that gradually for the past one-and-a-half -two years, he has started developing doubts regarding his sexuality and at present that doubt has magnified to the level of repetitive, obsessive thoughts. As far as he can remember, the first doubt came in his mind when he was a part of a discussion among his male friends and he realized that his level of engagement in masturbatory behavior is significantly lesser than his peers. As per the client, he started doubting his sexual orientation even more when he started thinking that his thought process and areas of interest and hobbies are also not in alignment with the idea of 'perceived

masculinity'. He described that as he was emotionally sensitive, had an artistic bent of mind, interested in painting and photography; he started feeling that he was not 'masculine enough' to be heterosexual. He also started seeing his care, concern and healthy reciprocal friendship through the lens of obsessive doubt regarding his sexuality. He indicated that he maintained physical distance from other men in all public places. If another man walked into a room, particularly in photo studios at work, he would place his hands behind his back in an effort to avoid touching them. Gradually he had started becoming vigilant towards his surroundings in any public space and started observing body language, signs, gestures, dress and appearance to infer who was homosexual and who was not. As reported, at present the checking behavior has escalated to the level of finding and checking for signs of homosexuality in him. He had started developing a compulsive behavior to avoid situations and places which could work as a trigger for his obsessive thoughts and anxiety, for instance getting intimate with his girlfriend, going to a fashion photography event or a photography exhibition. In the last five-six months, he has also started developing pervasively low mood and has also started developing a tendency to get agitated or irritable at the slightest of setbacks. He has also started feeling a lack of interest and motivation in earlier pleasurable activities. He does not feel like socializing as before. He also feels a lack of confidence in attempting any task or activity.

## **V. Assessment**

### **5.1. Yale-Brown Obsessive Compulsive Scale (YBOCS)**

The client obtained a score of '22' in the Y-BOCS which is indicative of the presence of obsessive and compulsive symptoms at moderate severity level. The symptom checklist indicates that the symptoms present in the client included fear of doing something embarrassing, forbidden or perverse sexual thoughts, images or impulses, pervasive thoughts the content of which involves homosexuality, fear of saying certain things, excessive concern with aspects of appearance, avoidance behavior and checking that nothing terrible did or will happen.

### **5.2. Beck Depression Inventory (BDI)**

The client obtained a score of 25 which indicates the presence of 'clinical depression' at the moderate level. Features of depression present in the client include lack of motivation and interest, lack of confidence, reduced interest in sex, reduced level of energy and pervasively low mood state.

### **5.3. Hamilton- Anxiety (HAM-A) Rating Scale**

The client has obtained a score of 18 which indicates the presence of anxiety at mild to moderate severity level. The features present in the client include tension, depressed mood, genitourinary symptoms like loss of libido and autonomic symptoms like dry mouth, tendency to sweat and headache.

## **VI. Case Conceptualization**

The client's symptoms can be best understood with a cognitive-behavioral conceptualization of OCD. The intrusive, distressing thoughts are mostly regarding his sexual orientation and also lead to obsessive doubts. He experienced frequent intrusive thoughts about possibly being gay. He interpreted these thoughts as significantly distressing and made efforts not to face the triggers (situations, places or human company) to avoid having thoughts in the future. These avoidance strategies included avoidance of admirable or muscularly built men, crowded public places where he would have to stay with men in close proximity for instance in an elevator, an art exhibition or a fashion assignment. When bound to be in such situations, he would create physical distance between himself and the other men, be very self-conscious and be scared of touching someone, doing something embarrassing or be tormented by intrusive thoughts and doubts regarding his sexuality. These avoidance strategies served to decrease the anxiety S.D was experiencing in the short term. By removing himself from triggers 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, S.D's avoidance deprived him from the social and recreational activities from his life and caused hindrance in his creative assignments and socialization. Increased social isolation and stress contributed to the manifestation 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., the situations, places or company mentioned) that nothing bad (i.e., participating in sexual activity with another man or discover that his sexuality is changing) would happen. Because his strategy of avoidance worked temporarily reducing anxiety, S.D saw avoidance as a necessary strategy. Thus, in the future when an intrusive thought about being gay occurred, he avoided other men or created physical distance or avoided such

situations when total avoidance was not possible. In this way, S.D continued the cycle of intrusive thought, avoidance and temporary relief from anxiety. In addition to the distress cause by anxiety and the intrusive, repetitive thoughts; the frustration regarding the feeling of losing control over his thoughts, S.D has also developed a pervasively low mood state, lack of energy, lack of interest and motivation and reduced libidinal energy.

## **VII. Course of treatment and assessment of progress**

### **7.1. Treatment Plan and Goals**

The treatment plan was formulated keeping in mind the primary reason for visit of the client and his primary source of distress. The client expressed that he will feel much better if his mind was free of these intrusive and extremely distressing thoughts. The treatment plan is formulated under three domains:

#### **7.1.1. Incorporating mindfulness techniques**

Incorporating mindfulness techniques was planned to create acceptance towards his thoughts irrespective of what these thoughts are; which will ensure that the distress and anxiety associated with these thoughts reduce.

#### **7.1.2. Cognitive restructuring**

Cognitive restructuring was planned to deal with the faulty irrational beliefs, cognitive distortions and stereotypical ideas and conception that the client has towards sexuality.

#### **7.1.3. Exposure and response prevention (ERP)**

ERP is planned to be implemented to gradually reduce the avoidance behavior and other existing compulsive behavior, with the help of graded exposure, relaxation and response prevention. The graded exposure is determined on the basis of a hierarchical list of situations and places that he avoids in the ascending order of subjective unit of distress (SUD). Hence, a preliminary assessment is planned to know the existing triggers, the distressing thoughts and the conscious efforts he makes in the form of avoidance behavior to avoid such situations.

### **7.2. Therapist and Relational Factors**

The therapist essentially plays the role as a facilitator and tries to be in the same platform as the client avoiding any authoritarian stance. It has been brought up by the client in the initial sessions that the female gender of the therapist has been a positive contributory factor to rapport establishment and the progress of therapy. The client mentioned that he would have been anxious and uncomfortable in case he had to undergo therapy with a male therapist.

From the therapist's point of view it is to be mentioned that the therapist has past experience of working with individuals suffering from OCD. As per the subjective experience of the therapist, CBT along with the integration of mindfulness techniques has worked effectively in the alleviation of compulsions as well as obsessive thoughts. However, it is significant to note that arriving at a diagnosis needed much deliberation by the client as well as therapist.

### **7.3. Course of Treatment**

#### **7.3.1. Psycho-education and lifestyle changes**

The course of therapeutic intervention started with psycho-education of the client. Regular physical exercise as simple as a morning walk and a brief evening walk was introduced as the client is fond of physical sports in general (and is deprived of it due to the avoidance symptoms) and to address the symptoms of depression like lack of motivation and energy.

#### **7.3.2. Self-monitoring practices incorporated**

In the next step, the client was explained how the obsessive thoughts are formed and how the distress and anxiety associated with the thoughts gradually exacerbates. The first step of addressing the obsessive thoughts is to identify them. Self-monitoring practices were introduced to address the thoughts. The client was advised to maintain a record of the obsessive thoughts, to identify the nature of thoughts, the common patterns and the underlying triggers and also as a means of ventilation.

#### **7.3.3. Assessment as a part of the Exposure and Response Prevention (ERP) Treatment Protocol**

Included in the ERP 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. During the first two ERP sessions, the client was evaluated to help determine what his particular triggers were along with any avoidance strategies he was using. The situations he avoided as they triggered anxiety were listed eventually.

#### **7.3.4. Listing out the different forms of compulsions**

In this step, the concentration was on understanding the different forms of compulsions the client engages in. It was explained how compulsions led to a temporary sense of relief but how anxiety again returned with the original intensity. This eventual cyclic pattern was explained again. Some of the identified compulsions were overt and mostly constituted of avoidance behavior which was implemented to avoid the situational triggers. The other identified triggers were subjective triggers and it was elicited that he also engaged in covert neutralization to deal with these triggers. The respective triggers and the compulsions that he engaged in were all listed down.

#### **7.3.5. Rating of discomfort (distress)**

The next step in the procedure was to collaborate with the client and rate the level of distress that each of the situational triggers caused as a result of which he engaged in the compulsions. The rating was done on a subjective unit of distress scale ranging from 0 to 100 (SUDS). The situations or triggers are then arranged in hierarchical order with gradual ascension of the rating of subjective unit of distress. This was later used as a basis for the planning of the exposures in the exposure and response prevention (ERP) module.

#### **7.3.6. Mindfulness Practices Applied to address the distress caused by the intrusive thoughts**

Some mindfulness exercises were introduced to address the distress associated with the obsessive thoughts which stem from the judgmental stance due to the constant vigilance by the meta-cognitive layer of the mind. The rationale behind the mindfulness practices was explained. It was elaborated how these mindfulness practices aim to replace the judgmental, vigilant stance of the mind towards our thoughts with a non-judgmental accepting stance. The purpose of replacing the auto-pilot, anxiety ridden state of the mind with present moment awareness was also explained. The mindfulness exercises were then demonstrated and advised to be continued.

#### **7.3.7. Identifying cognitive distortions and cognitive restructuring**

In this phase, with the help of the self-monitoring thought record maintained by the client the cognitive distortions and the thought errors were identified. Besides these, a lot of faulty assumptions and beliefs regarding sexuality specifically homosexuality could also be identified. The goal in this step was to address these distortions and replace them with rational, adaptive thoughts. The faulty assumptions and beliefs regarding sexuality were also addressed as these misconceptions led to hurried assumptions and vigilance in the client to figure out the gender identity of people around him which in itself is a false notion.

#### **7.3.8. Graded exposure to all previously avoided situations**

In this step, as a part of ERP the client was gradually exposed hierarchically starting with the situation which causes the least amount of distress to the one which causes the most. The goal was to prevent him from engaging in any of the avoidance behavior or neutralizing behavior and observing how the anxiety reduces eventually with the passage of time even if he does not engage in the compulsions.

#### **7.3.9. Prevention of compulsive rituals and neutralizing behaviors**

The gradual exposure and prevention of engaging in compulsions was continued gradually in the hierarchical order. With every success, it was noted that the self esteem of the client also started to improve as he felt more in control of his thoughts and behavior.

#### **7.3.10. Incorporating mindfulness into daily routine**

In the maintenance phase of intervention, gradually mindfulness practices were incorporated into his daily routine so that acceptance, non-judgmental stance and present moment awareness become his way of living. This was done to ensure that no thought no matter how absurd or strange ever leads to judgment, guilt or

distress; and he can live at the present moment fully without the baggage of anxiety. These practices also ensure better cognitive functioning and holistic living.

#### **7.4. Concluding the evaluation of therapy process and assessment of outcome**

The post-therapy assessment of the client indicated alleviation of the features of depression, anxiety, obsessive thoughts and compulsions.

The post-assessment scores obtained are mentioned below:

- Yale-Brown Obsessive Compulsive Scale (YBOCS): 9 (none to mild symptoms)
- Beck Depression Inventory (BDI): 10 (normal ups and downs of mood)
- Hamilton- Anxiety (HAM-A) Rating Scale: 8 (none to mild anxiety levels)

Besides these, the general tendency of the client to repress all his thoughts and emotions successfully addressed. It was ensured that the client developed a healthy habit of ventilating or expressing his thoughts and emotions rather than keeping it all bottled up.

The client also ended up with more rational, realistic and scientific ideas regarding gender identity, sexuality and sexual orientation. His stereotypical ideas about masculinity and the myths associated with homosexuality could be eradicated up to a large extent.

### **VIII. Discussion**

This case study enhances the understanding of a specific form of psychopathology and intervention from two perspectives. The first objective was to understand the manifestation of homosexual-OCD in the context of stereotypical ideas and beliefs regarding the concepts of sexual orientation and homosexuality, especially with respect to men. The dominant discourses regarding sexuality and gender roles are driven by stereotypical beliefs such as:

- All men are effeminate. Hence, homosexuality is somehow related to lack of masculinity.
- Artistic and creative professions like designing, creative art and photography are the forte of women and gay men.
- Physical sports, using swear words, being emotionally stoic are signs of masculinity.
- Being artistic, emotionally sensitive, soft-spoken, polite and vulnerable are signs of femininity in a man.
- A man is supposed to have more sexually explorative tendency than a woman.
- Men are supposed to be more sexually active than women.

These are some of the widely prevalent stereotypical beliefs about sexuality and gender roles in the Indian socio-cultural context which have played an instrumental role in the snowballing doubt in the client's mind regarding his sexual orientation. It is significant to mention that these strongly reinforced ideas and beliefs about sexuality and homosexuality in specific can lead to very rigid and concrete ideas regarding sexuality. Any deviation that an individual notices when seen through the lens of anxiety has the chance of forming doubt and discomfort with oneself.

The second objective is evaluating the efficacy of cognitive behavior therapy (CBT) along with mindfulness techniques in alleviating the features of hOCD. Through the therapeutic procedure one could arrive at the conclusion that exposure and response prevention is undoubtedly an effective mode to reduce the compulsive behavior. Cognitive restructuring is an effective mode of therapeutic process in identifying the cognitive distortions especially pertaining to sexuality and gender orientation. Mindfulness technique is the most evidence-based and indicated approach in dealing with distress caused by anxiety-ridden thoughts. Mindfulness approach helps in normalizing and shifting the vigilant, judgmental, 'auto-pilot' stance of the mind into accepting, mindful and non-judgmental stance. Besides, the advantages of incorporating mindfulness skills in his daily life ensure reducing the level of anxiety in general and having a richer experience of living fully at the present moment.

## IX. Conclusion

To conclude, it might be stated that the process of cognitive behavior therapy (CBT) along with mindfulness techniques were proven to be effective in addressing the features of obsession and compulsion; as well as in reducing the subjective level of distress associated with the thoughts. The advantages of mindfulness techniques encompass the disorder and also help in incorporating some practices into the daily life of an individual which would work as significant preventive factors for relapse or the culmination of any other mental health issue.

## X. Complicating Factors

The initial approach of the client towards therapy posed as a complication during the initial phase. The client had a prejudice towards therapy and seeking help, which had been reinforced over the years by stereotypical beliefs of his family. As per the client's report, he initially perceived coming to therapy as a failure of his coping resources and a sign of lack of mental strength.

It was noted that the client had difficulty expressing his emotions. This posed as a complication at times as the client felt discomfort in expressing the intricacies of his obsessive thoughts and underlying anxiety as he felt embarrassed discussing the details and feared being judged. Though the difficulty gradually eased out as the client grew comfortable with each progressing session.

## XI. Access and Barriers to Care

The only relation of the client that could be used to corroborate information is his girlfriend. She was supportive all through the therapeutic process.

The only major limitation in the process of therapy was not having significant informants as the client was unable to share or express about this issue with no one else apart from his girlfriend. It was impossible for him to share these issues with his family as there is a generation gap and also more stigma and stereotypical beliefs associated with mental health issues as well as sexual orientation in his family.

There was no such barrier in the process of access to the mental health care services apart from the initial psychological barrier because of the stereotypical beliefs of the client in relation to seeking help for mental health issues.

However, it is to be mentioned that the client played a very proactive role in the whole process of therapeutic intervention. He was cooperative throughout the process and adhered to the therapeutic procedure as much as possible. His restlessness to get better considering that he used to be a very active, productive and sociable individual; worked as an impetus in the therapeutic process.

## XII. Follow-up

Follow-up sessions were planned after discussion with the client. The client had an apprehension regarding the sustainability of his improvement and follow-up sessions at a frequency of once a month was mutually agreed upon. The follow-up sessions were planned with the purpose of maintaining the improvement for another six months. By the end of the sixth follow-up session, the client was confident about the sustainability of his improvement. It was communicated to the client that he could contact at his own volition if he ever feels the need for a session. However, it is to be noted that the client continued to function well and did not feel the need to contact for therapy after the termination session.

## XIII. Treatment Implications to the case

- The case study implicates the importance of a non-judgmental stance in alleviating the distress caused by recurrent, repetitive and obsessive thoughts.
- The case study implicates the effectiveness of cognitive restructuring not only in dealing with the cognitive distortions but also in replacing the stereotypical beliefs regarding sexual orientation with rational thoughts.
- This case study implicates the need for clinicians in practice to be more gender sensitive in their therapeutic communication.
- This case study also implicates the possibilities and scopes that an open communication about gender role and subjective ideas about gender identity could have in understanding the construction of the self-image, self-esteem and feelings of inadequacy.
- This case study implicates the importance of the theoretical construct of homophobia, homosexual anxiety and the heavily laden stereotypical ideas about gender and sexuality.

- This case study implicates the need for more research studies in the future to explore the prevalence of this specific form of OCD spectrum disorder in the population.

#### **XIV. Recommendations to the Clinicians and Students**

- It can be recommended to the practicing clinicians to use mindfulness in integration with CBT to address the distress and anxiety caused by the obsessive thoughts more effectively.
- It can be recommended to the practicing clinicians to be more gender sensitive and avoid presumptions around sexuality in their therapeutic conversations and communications.
- It can be recommended for the clinicians to explore the possibility of the impact of social discourses and stereotypical beliefs around sexuality in the construction of gender identity, gender roles and self image in general.
- It can be recommended to students explore the possibility of such rare manifestations under the umbrella of common psychological disorders.
- It can be recommended to the students to pursue research in the future to explore the contribution of dominant social discourses and usage of language in the formation of the concept of gender roles and sexuality.

#### **References**

- 1) Baer, R.A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10, 125–143.
- 2) Bernal Crespo, Julia Sandra, Orozco Arcieri, Carlos Andrés, & Molinares Hassan, Viridiana. (2016). Foucault and Homosexuality: From Power Relation to Practice of Freedom. *Revista de Derecho*, (46), 111-130. <https://dx.doi.org/10.14482/dere.46.8813>
- 3) Bhatia, M. S., & Kaur, J. (2015). Homosexual Obsessive Compulsive Disorder (HOCD): A Rare Case Report. *Journal of clinical and diagnostic research : JCDR*, 9(1), VD01–VD02. <https://doi.org/10.7860/JCDR/2015/10773.5377>
- 4) Chambers, R., Lo, B.C.Y. & Allen, N.B. The Impact of Intensive Mindfulness Training on Attentional Control, Cognitive Style, and Affect. *Cogn Ther Res* 32, 303–322 (2008). <https://doi.org/10.1007/s10608-007-9119-0>
- 5) Cludius, Barbara & Hottenrott, Birgit & Heike, Alsleben & Ulrike, Peter & Schröder, Johanna & Moritz, Steffen. (2015). Mindfulness for OCD? No evidence for a direct effect of a self-help treatment approach. *Journal of Obsessive-Compulsive and Related Disorders*. 6. 10.1016/j.jocrd.2015.05.003.
- 6) Coimbra Gomes, Elvis. (2016). "What if I'm Gay?": A Corpus Analysis of Sexual Orientation Obsessive-Compulsive Disorder (SO-OCD) Narratives. 10.13140/RG.2.1.5066.3764.
- 7) Coimbra-Gomes, E., & Motschenbacher, H. (2019, August 21). Language, normativity, and sexual orientation obsessive-compulsive disorder (SO-OCD): A corpus-assisted discourse analysis. Retrieved January 9, 2020, from <https://www.cambridge.org/core/journals/language-in-society/article/language-normativity-and-sexual-orientation-obsessivecompulsive-disorder-soocd-a-corpusassisted-discourse-analysis/CD8F5EBF3C1D62E1782E36C0D5E3D44A/core-reader#>
- 8) Fairfax, H. (2018). Mindfulness and Obsessive Compulsive Disorder; Implications for Psychological Intervention. *Journal Of Mental Health And Clinical Psychology*, 2(4), 55–63. doi: 10.29245/2578-2959/2018/4.1146
- 9) Fairfax, Hamilton. (2008). The use of mindfulness in obsessive compulsive disorder: Suggestions for its application and integration in existing treatment. *Clinical psychology & psychotherapy*. 15. 53-9. 10.1002/cpp.557.
- 10) Foa, E. B. (2010, June 12). Cognitive behavioral therapy of obsessive-compulsive disorder. Retrieved January 1, 2020, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181959/>
- 11) Franklin, Martin & Foa, Edna. (2011). Treatment of Obsessive Compulsive Disorder. *Annual review of clinical psychology*. 7. 229-43. 10.1146/annurev-clinpsy-032210-104533.

- 12) Gay OCD/ HOCD Treatment. (2010, October 28). Retrieved January 9, 2020, from <https://ocdla.com/sexual-orientation-hocd-gay-ocd-treatment-2-1970>
- 13) Goodwin, Renee & Koenen, Karestan & Hellman, Fred & Guardino, Mary & Struening, Elmer. (2002). Helpseeking and access to mental health treatment for obsessive-compulsive disorder. *Acta psychiatrica Scandinavica*. 106. 143-9. 10.1034/j.1600-0447.2002.01221.x.
- 14) Gordon, William. (2002). Sexual obsessions and OCD. *Sexual and Relationship Therapy*. 17. 343-354. 10.1080/1468199021000017191.
- 15) Grant, Jon & Pinto, Anthony & Gunnip, Matthew & Mancebo, Maria & Eisen, Jane & Rasmussen, Steven. (2006). Sexual obsessions and clinical correlates in adults with obsessive-compulsive disorder. *Comprehensive psychiatry*. 47. 325-9. 10.1016/j.comppsy.2006.01.007.
- 16) Hale, Lucy & Strauss, Clara & Lever Taylor, Billie. (2013). The Effectiveness and Acceptability of Mindfulness-Based Therapy for Obsessive Compulsive Disorder: A Review of the Literature. *Mindfulness*. 4. 10.1007/s12671-012-0137-y.
- 17) Hanstede, M., Gidron, Y., & Nyklíček, I. (2008, October). The effects of a mindfulness intervention on obsessive-compulsive symptoms in a non-clinical student population. Retrieved December 22, 2019, from <https://www.ncbi.nlm.nih.gov/pubmed/18852623>
- 18) Keng, S. L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: a review of empirical studies. *Clinical psychology review*, 31(6), 1041–1056. <https://doi.org/10.1016/j.cpr.2011.04.006>
- 19) Kessler, Ronald & Berglund, Patricia & Demler, Olga & Jin, R. & Merikangas, Kathleen & Walters, E.E.. (2005). Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arc Gen Psychiatry* 62: 593-602. *Archives of General Psychiatry*. 62. 10.1001/archpsyc.62.7.768.
- 20) Khanna, S., & Greeson, J. M. (2013). A narrative review of yoga and mindfulness as complementary therapies for addiction. *Complementary therapies in medicine*, 21(3), 244–252. <https://doi.org/10.1016/j.ctim.2013.01.008>
- 21) Mindfulness and Obsessive Compulsive Disorder; Implications for Psychological Intervention. (2018, August 28). Retrieved December 16, 2019, from <https://www.mentalhealthjournal.org/articles/mindfulness-and-obsessive-compulsive-disorder-implications-for-psychological-intervention.html>
- 22) Samuel, D. B., Lynam, D. R., Widiger, T. A., & Ball, S. A. (2012, January). An expert consensus approach to relating the proposed DSM-5 types and traits. Retrieved January 5, 2020, from <https://www.ncbi.nlm.nih.gov/pubmed/22448858>
- 23) Schwartz, D. J. (n.d.). Dr. Jeffrey Schwartz's Four Steps for OCD. Retrieved January 2, 2020, from <http://hope4ocd.com/foursteps.php>
- 24) Shonin, E., & Van Gordon, W. (2016). The Mechanisms of Mindfulness in the Treatment of Mental Illness and Addiction. *International journal of mental health and addiction*, 14(5), 844–849. <https://doi.org/10.1007/s11469-016-9653-7>
- 25) Shonin, E., & Van Gordon, W. (2016). The Mechanisms of Mindfulness in the Treatment of Mental Illness and Addiction. *International journal of mental health and addiction*, 14(5), 844–849. <https://doi.org/10.1007/s11469-016-9653-7>
- 26) Strauss, C., Lea, L., Hayward, M., Forrester, E., Leeuwrik, T., Jones, A.-M., & Rosten, C. (2018, April 30). Mindfulness-based exposure and response prevention for obsessive compulsive disorder: Findings from a pilot randomised controlled trial. Retrieved December 28, 2019, from <https://www.sciencedirect.com/science/article/pii/S0887618517305315>
- 27) Telles, S., Raghavendra, B. R., Naveen, K. V., Manjunath, N. K., Kumar, S., & Subramanya, P. (2013). Changes in Autonomic Variables Following Two Meditative States Described in Yoga Texts. *The Journal of Alternative and Complementary Medicine*, 19(1), 35–42. doi: 10.1089/acm.2011.0282
- 28) Thomas, T. A., & Fremouw, W. J. (2009, September 15). Homosexual Panic. Retrieved January 5, 2020, from <https://onlinelibrary.wiley.com/doi/abs/10.1002/9780470061589.fsa503>

- 29) Turner, S. C. (2013, June 1). Mindfulness 101: Urge Surfing. Retrieved December 11, 2020, from <http://dbtin3months.blogspot.com/2013/06/urge-surfing.html>
- 30) Williams, M. T., & Farris, S. G. (2011). Sexual orientation obsessions in obsessive-compulsive disorder: prevalence and correlates. *Psychiatry research*, 187(1-2), 156–159. <https://doi.org/10.1016/j.psychres.2010.10.019>
- 31) Williams, M. T., Crozier, M., & Powers, M. (2011). Treatment of Sexual-Orientation Obsessions in Obsessive-Compulsive Disorder Using Exposure and Ritual Prevention. *Clinical case studies*, 10(1), 53–66. <https://doi.org/10.1177/1534650110393732>
- 32) Williams, M. T., Farris, S. G., Turkheimer, E. N., Franklin, M. E., Simpson, H. B., Liebowitz, M., & Foa, E. B. (2014). The impact of symptom dimensions on outcome for exposure and ritual prevention therapy in obsessive-compulsive disorder. *Journal of anxiety disorders*, 28(6), 553–558. <https://doi.org/10.1016/j.janxdis.2014.06.001>

