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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 eight percent ($n = 33$) 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 ($p = .055$). 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.

Keywords

obsessive compulsive disorder; assessment; sexual obsessions; sexual orientation

1. Introduction

Obsessive compulsive disorder 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.), while current (12-month) rates range from 0.6% to 1.3% (Crino, Slade, Andrews, 2005; Ruscio et al.). 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

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significantly higher among females than males (Ruscio et al.) 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 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 & 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 of 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 9 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 (5 questions) and the compulsions subscale (5 questions), followed by supplementary items that do not contribute to the total severity scale score. YBOCS severity scale scores ≤ 16 are considered sub-clinical, and a score ≥ 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 0-4, 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 $\alpha = .92$). 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 ($p = .048$). 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 ($p = .031$), more interference from obsessions ($p = .007$), and more distress from obsessions ($p = .001$). 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; $p = .055$).

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 [$t(47) = 1.32, p = .19$; mean age was 36.7 ± 14.3 for current and 31.6 ± 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. (2006) did not find that gender was correlated with sexual obsessions, we found that significantly more males reported sexual orientation obsessions. Age does not appear be uniquely associated with obsessions about sexual orientation. Our sample of patients with obsessions about sexual orientation was similar in age to other treatment-seeking populations (i.e., Abramowitz et al., 2003), and this did not vary from patients with other OCD symptom types. Additionally, patients in the current study with obsessions about sexual orientation reported moderate OCD severity and comparable levels of insight to patients with other types of OCD symptoms, which is consistent with findings by Grant and colleagues.

Our findings indicate that obsessions about sexual orientation in OCD may be uniquely associated with increased time spent on obsessions, increased levels of distress, more interference, and more avoidance, all which may be clinically relevant for the assessment and treatment of OCD. Notably, as males tend to have an earlier age of onset of OCD symptoms, they may experience more distress from symptoms because the symptoms have been presenting for a longer period of time. Sexual orientation obsessions may be more distressing, resulting in greater disability and greater need for treatment services. Likewise, the stigma and/or misdiagnosis of homosexuality-themed OCD might result in delays in finding the most appropriate treatment, resulting in increased distress as symptoms progress untreated.

People with OCD may have a number of different obsessions and compulsions, thus careful assessment of OCD symptoms is necessary. Other types of obsessions may be more recognizable to clinicians (e.g., concerns about contamination) and more comfortable for patients to discuss, which may result in obsessions about sexual orientation being missed in treatment. It is important to note that the clinicians administering the YBOCS in the current study were primarily from specialty clinics, so were highly familiar with assessing OC symptoms. OCD can pose a unique diagnostic challenge to clinicians, and among those not experienced in the assessment and treatment of sexual obsessions in OCD, misdiagnoses or ineffective treatment can result (Gordon, 2002; Grabill et al., 2008; Sussman, 2003). Patients presenting with OCD should be asked directly about the presence of sexual obsessions, including fears surrounding sexual orientation. Clinicians should be careful not to imply that they believe the patient is homosexual, as this will cause distress and potentially a loss of rapport (Williams, 2008).

Contributing to misunderstandings about the nature of sexual obsessions, some research categorizes sexual obsessions and compulsivity together with deviant behavior (e.g., Branaman, 1996). The DSM specifically notes while engaging in excessive sexual behaviors may be often referred to as ‘compulsive’ behavior, this is actually incorrect. In such situations, the “individual derives pleasure from the activity and may wish to resist it only because of its deleterious consequences” (APA, 2004). What is often described as “compulsive sexual behavior” is actually more accurately describing impulsivity, as individuals experience thoughts, impulses, and behaviors as enjoyable, not distressing. This differential distinction is essential when considering a diagnosis of OCD, as obsessions are unpleasant and do not represent fantasies or wishes.

There is no evidence to suggest that people with sexual orientation-themed OCD should receive any treatment other than what has already been established as efficacious for OCD in general. The most common pharmacological treatment for obsessive-compulsive disorder is a selective serotonin reuptake inhibitors (SSRI) or the tricyclic medication clomipramine, where dosages for the anti-obsessional qualities are often higher than typically needed for anti-depressant effects (Blanco et al., 2006; Bystritsky, 2004). It is not known if people with sexual orientation obsessions fare better or worse than people with other OCD symptom profiles. For example, in a study investigating the treatment effects of citalopram, sexual thoughts were a predictor of positive medication response (Stein et al., 2007); however, in another SRI study individuals with sexual obsessions had poorer long-term outcomes (Alonzo et al., 2001).

In terms of psychotherapeutic interventions for OCD, research suggests that, compared to most other forms of OCD (i.e., contamination or checking), sexual obsessions take longer to treat (Grant et al., 2006), and response may be less robust (Alonso et al., 2001; Mataix-Cols et al., 2002; Rufer et al., 2006). However, EX/RP remains the treatment of choice for those with sexual obsessions, with cognitive therapy as a possible second-line alternative (e.g.,

NICE, 2006). People with sexual obsessions are less likely to have overt rituals, and more likely to engage in mental compulsions and repeated reassurance-seeking (Abramowitz et al., 2003; Farris et al., 2010), so special attention should be given to covert rituals during treatment.

The current study has a few notable limitations. We examined patients with lifetime symptoms for most comparisons as we did not have adequate power to examine only those with current sexual orientation symptoms. This approach as has been utilized previously to examine symptoms dimensions based on the YBOCS check list (Pinto et al., 2008). It is possible that those without current symptoms may be different in some important ways than those with only a history of such symptoms, although it appears that presence of sexual obsessions tends to be stable over time (Besiroglu et al., 2007). A future study should examine this issue with large numbers of people with past, present, and no history of sexual orientation symptoms for comparison. Additionally, it is possible that obsessions about sexual orientation are associated with another type of particularly distressing or impairing obsession or compulsion (e.g., aggressive obsessions), which could result in higher YBOCS severity scores. It was not possible to test this idea in the current study due to limitation concerning the availability of all variables; however, future studies should explore this as well. An examination of the similarities and differences between different types of sexual obsessions would also be a useful and interesting avenue of future research.

Obsessions about sexual orientation are consuming to those experiencing them, and sometimes puzzling to clinicians assessing and treating them. Our findings suggest that those with obsessions about sexual orientation spend more time worrying and ruminating, feel increased distress and shame, and may be more impaired. Thus it is critical that people with sexual orientation concerns be properly diagnosed and treated. Failure to identify these symptoms can result in incorrect treatment, incomplete treatment, and/or relapse.

It has not been established how to best tailor cognitive-behavioral treatments to this particular group of patients, and likewise it is not known if some medications may be more effective for sexual orientation obsessions than others, thus more treatment-focused research is needed. Future studies should include analyses of symptom data from epidemiological studies and investigation of treatment outcome data, as it would provide greater insight into this often misunderstood symptom of OCD.

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References

- Abramowitz JS, Franklin ME, Schwartz SA, Furr JM. Symptom presentation and outcome of cognitive-behavioral therapy for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*. 2003; 71:1049–1057. [PubMed: 14622080]
- Alonso P, Menchón JM, Pifarré J, Mataix-Cols D, Torres L, Salgado P, Vallejo J. Long-term follow-up and predictors of clinical outcome in obsessive-compulsive patients treated with serotonin reuptake inhibitors and behavioral therapy. *Journal of Clinical Psychiatry*. 2001; 62:535–540. [PubMed: 11488364]
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. American Psychiatric Press; Washington D.C.: 2004. Text Revision

- Besiroglu L, Uguz F, Ozbebit O, Guler O, Cilli A, Askin R. Longitudinal assessment of symptom and subtype categories in obsessive-compulsive disorder. *Depression and Anxiety*. 2007; 24:461–466. [PubMed: 17131352]
- Blanco C, Olfson M, Stein DJ, Simpson HB, Gameroff MJ, Narrow WH. Treatment of obsessive-compulsive disorder by U.S. psychiatrists. *Journal of Clinical Psychiatry*. 2006; 67:946–951. [PubMed: 16848654]
- Branaman TF. The role of fantasy in the evaluation and treatment of sexual obsessions and compulsivity. *American Journal of Forensic Psychology*. 1996; 14:39–48.
- Bystritsky A. Current Pharmacological Treatments for Obsessive-Compulsive Disorder. *Essential Psychopharmacology*. 2004; 5:4.
- Crino R, Slade T, Andrews G. The changing prevalence and severity of obsessive-compulsive disorder criteria from DSM-III to DSM-IV. *American Journal of Psychiatry*. 2005; 162:876–882. [PubMed: 15863788]
- Eisen JL, Phillips KA, Baer L, Beer DA, Atala KD, Rasmussen SA. The Brown Assessment of Beliefs Scale: Reliability and validity. *American Journal of Psychiatry*. 1998; 155:102–108. [PubMed: 9433346]
- Farris, SG.; Mugno, BL.; Williams, MT.; Franklin, ME.; Foa, EB. The myth of the pure obsessional: Compulsions in taboo thoughts. Poster session presented at the annual meeting of the International Obsessive-Compulsive Foundation; Arlington, VA. July. 2010
- Foa EB, Kozak MJ, Goodman WK, Hollander E, Jenike MA, Rasmussen SA. DSM-IV field trial: Obsessive-compulsive disorder. *American Journal of Psychiatry*. 1995; 152:90–96. [PubMed: 7802127]
- Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR, Charney DS. The Yale-Brown Obsessive Compulsive Scale, I: Development, use, and reliability. *Archives of General Psychiatry*. 1989; 46:1006–1011.
- Gordon WM. Sexual obsessions and OCD. *Sexual and Relationship Therapy*. 2002; 17:343–354.
- Grabill K, Merlo L, Duke D, Harford KL, Keeley ML, Gefken GR, Storch EA. Assessment of obsessive-compulsive disorder: A review. *Journal of Anxiety Disorders*. 2008; 22:1–17. [PubMed: 17367988]
- Grant JE, Pinto A, Gunnip M, Mancebo MC, Eisen JL, Rasmussen SA. Sexual obsessions and clinical correlates in adults with obsessive-compulsive disorder. *Comprehensive Psychiatry*. 2006; 47:325–329. [PubMed: 16905392]
- 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. *Archives of General Psychiatry*. 2005; 62:593–602. [PubMed: 15939837]
- Mataix-Cols D, Marks IM, Greist JH, Kobak KA, Baer L. Obsessive compulsive symptom dimensions as predictors of compliance with and response to behaviour therapy: Results from a controlled trial. *Psychotherapy and Psychosomatics*. 2002; 71:255–262. [PubMed: 12207105]
- NICE. Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. The British Psychological Society & The Royal College of Psychiatrists; 2006. www.nice.org.uk
- Obsessive Compulsive Cognitions Working Group. Psychometric validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory: Part 1. *Behaviour Research and Therapy*. 2003; 41:1245–1264.
- Pinto A, Eisen JL, Mancebo MC, Greenberg BD, Stout RL, Rasmussen SA. Taboo thoughts and doubt/checking: A refinement of the factor structure for obsessive compulsive disorder symptoms. *Psychiatry Research*. 2007; 151:255–258. [PubMed: 17368563]
- Pinto A, Greenberg B, Grados M, Bienvenu O III, Samuels J, Murphy D, Hasler G, Stout RL, Rauch SL, Shugart YY, Pauls DL, Knowles JA, Fyer AJ, McCracken JT, Piacentini J, Wang Y, Willour VL, Cullen B, Liang K-Y, Hoehn-Saric R, Riddle MA, Rasmussen SA, Nestadt G. Further development of Y-BOCS dimensions in the OCD Collaborative Genetics Study: Symptoms vs. categories. *Psychiatry Research*. 2008; 160:83–93. [PubMed: 18514325]
- Renaud CA, Byers ES. Exploring the frequency, diversity, and content of university students' positive and negative sexual cognitions. *The Canadian Journal of Human Sexuality*. 1999; 8:17–30.

- Ruck C, Bergstrom J. Is the Y-BOCS discriminatory against gays and lesbians? *American Journal of Psychiatry*. 2006; 163(8):1449. [PubMed: 16877665]
- Rufer M, Fricke S, Moritz S, Kloss M, Hand I. Symptom dimensions in obsessive-compulsive disorder: Prediction of cognitive-behavior therapy outcome. *Acta Psychiatrica Scandinavica*. 2006; 113:440–446. [PubMed: 16603035]
- Ruscio AM, Stein DJ, Chiu WT, Kessler RC. The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Molecular Psychiatry*. 2010; 15:53–63. [PubMed: 18725912]
- Samuels JF, Riddle MA, Greenberg BD, Fyer AJ, McCracken JT, Rauch SL, Murphy DL, Grados MA, Pinto A, Knowles JA, Piacentini J, Cannistraro PA, Cullen B, Bienvenu J III, Rasmussen SA, Paules DL, Willour VL, Shugart YY, Liang KY, Hoehn-Saric R, Nestadt G. The OCD collaborative genetics study: Methods and sample description. *American Journal of Medical Genetics Part B (Neuropsychiatric Genetics)*. 2006; 141B:201–207.
- Sussman N. Obsessive-Compulsive Disorder: A Commonly Missed Diagnosis in Primary Care. *Primary Psychiatry*. 2003; 10:14.
- Williams, MT. Homosexuality anxiety: A misunderstood form of OCD. In: Sebeki, LV., editor. *Leading-Edge Health Education Issues*. Nova Science Publishers; New York: 2008. p. 195-205.

Table 1

Comparison of symptoms among OCD patients with lifetime sexual orientation obsessions

| | Obsessions about sexual orientation (n = 49) | No obsessions about sexual orientation (n = 360) | <i>t</i> or χ^2 |
|---------------------------------------|--|--|----------------------|
| n (%) Male | 32 (65.3%) | 179 (49.7%) | 4.19* |
| Age | 35.1 ± 12.7 | 35.9 ± 13.6 | .43 |
| YBOCS Severity Score | 21.5 ± 9.6 | 19.9 ± 12.9 | -.83 |
| Item 1 (Time spent on Obsessions) | 2.60 ± 0.89 | 2.24 ± 1.11 | -2.17* |
| Item 2 (Interference from Obsessions) | 2.31 ± 0.72 | 1.89 ± 1.05 | -2.70** |
| Item 3 (Distress from Obsessions) | 2.55 ± .79 | 2.09 ± .95 | -3.23** |
| Item 4 (Resistance of Obsessions) | 1.71 ± .97 | 1.73 ± 1.12 | .15 |
| Item 5 (Control over Obsessions) | 2.41 ± .96 | 2.24 ± 1.05 | -1.05 |
| Avoidance | 2.02 ± 1.12 | 1.68 ± 1.15 | -1.92 [†] |
| Insight | 0.78 ± 0.81 | 0.65 ± 0.81 | -1.05 |

*
 $p < .05$ **
 $p < .001$ [†]
 $p = .055$

Note. Responses for items 1 through 5 on the YBOCS range from 0 to 4, with lower scores indicating less severe symptoms. Avoidance item scores range from 0 to 4, with lower scores indicating less avoidance due to OCD. Insight item scores range from 0 to 4, with lower scores indicating more insight into OCD symptoms.