Sexual orientation and gender identity OCD: Addressing unique challenges related to diagnosis and treatment

Jennifer Park, PhD, and Tarik Hadžić, MD, PhD, presenters

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ROGERS Behavioral Health

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Disclosures

Jennifer Park, PhD, and Tarik Hadžić, MD, PhD, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

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What we'll cover in this webinar

Sexual orientation and gender identity OCD
- Brief overview of prevalence, presentation, and theories of development
- Presentation of OCD in LGBTQ+ populations
- Misidentification by professionals

Differential and diagnosis
- Differential between normal sexual orientation/gender identity development and SO-OCD and gender identity OCD
- Assessment tools and approaches

Treatment
- Brief overview of pharmacotherapy and CBT for OCD
- Application of exposure and response prevention (E/RP) with focus on reduction of stigma and minimizing reinforcement of stereotypes

Moderated Q&A

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. List two reasons professionals may misidentify SO-OCD/gender identity OCD for normative sexual orientation/gender identity development and vice versa.
2. Identify at least two ways to assess an individual to determine whether they are presenting with SO-OCD/gender identity OCD.
3. Formulate three exposures that minimize stigma and reduce reinforcement of stereotypes of the LGBTQ+ population when working with SO-OCD/gender identity OCD.

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Presenter subjectivities

Dr. Jennifer Park

Professional identities

- Executive Director of Clinical Services, Outpatient Services
- PhD, Clinical Psychologist
- Clinician, Researcher, Clinical Supervisor

Personal identities

- She/Her/Hers
- Korean-American, female cisgender
- Married with one child (2 yo son)

Dr. Tarik Hadžić

Professional identities

- Child, Adolescent and Adult Psychiatrist
- MD, PhD: Physician
- Clinician, Asst. Medical Director, Researcher

Personal identities

- He/Him/His
- Bosnian-American, cisgendered man
- Single

We acknowledge that our experience, intersectionality, privilege – and lack thereof – inform what we each bring to our research, clinical practice, and teaching

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Sexual orientation and gender identity OCD

Please use the Q&A feature to send your questions to the moderator.

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Overview: Prevalence, presentation, and theories of development

- OCD is a multi-faceted, heterogeneous disorder
- Meta-analyses confirmed validity of 4-factor analyses
  - Factor 1: Forbidden thoughts – aggression, sexual, religious, somatic obsessions and checking compulsions
  - Factor 2: Symmetry – symmetry obsessions and repeating, ordering and counting compulsions
  - Factor 3: Cleaning – contamination and cleaning
  - Factor 4: Hoarding – hoarding obsessions and compulsions

(Leckman et al., 2007)

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Overview: Prevalence, presentation, and theories of development

Sexual orientation OCD (SO-OCD)

- Falls under "forbidden thoughts" subtype
- Historically homosexual-OCD (H-OCD)
- Pathological doubts about one's sexual orientation; fears of being or becoming gay/lesbian/queer; fears others may think one is gay/lesbian/queer
- Prevalence needs more investigation
  - 30% with OCD report sexual/religious obsessions
  - 12% of those with OCD report lifetime SO-OCD obsessions (N = 409) (Williams & Farris, 2011)

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Overview: Prevalence, presentation, and theories of development

Gender identity OCD

- Less known, anecdotally increasing in prevalence
- Fears of being or becoming transgender, fears of uncertainty related to gender identity (heterosexual and LGBTQ+ community)
- Obsessions may be more likely to develop when stigma is greater (Williams et al., 2018)
  - Sexual minorities stigmatized group
  - May lead to heterosexual more fearful of being LGBTQ vs LGBTQ fearing being heterosexual

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Overview: Prevalence, presentation, and theories of development

Increased public scrutiny, salience in social media or news, and/or political discourse may contribute to increase in presentation of specific symptoms

- Contamination fears during COVID pandemic
- Fears of being perceived as white supremacists, Trump supporter
- Fears of being "cancelled"
- Fears of being transgender
  - Past decade estimates of those that identify as gender diverse doubled (Flores et al. 2016)
  - Gender identity considered more “taboo” than sexual orientation

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Overview: Prevalence, presentation, and theories of development

Sexual orientation OCD

- (N = 237, heterosexual)
- 91% report high levels of distress
  - 21% "suicidal" level of distress
  - 51% extreme distress

(Williams et al., 2015)

Gender identity OCD

Case study: Intrusive thoughts inducing intense fear described as "paralyzing“

(Safer et al., 2016)

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Presentation of OCD in LGBTQ+ populations

Sexual minorities

(identify as lesbian, gay, or bisexual)

- *N* = 515 nonclinical undergraduates
  - 10% sexual minority
- Sexual minorities reported significantly greater OCD–related unacceptable thoughts related to violence, sex or religion
  - Controlled for trauma and post traumatic symptoms
- More likely to exceed clinical cutoff for probable OCD

(Pinciotti & Orcutt, 2021)

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Presentation of OCD in LGBTQ+ populations

Gender minorities

(identify as transgender, gender non-conforming)

- *N* = 974 patients in specialty OCD treatment program
  - 1.7% gender minority
- Attenuated treatment response
  - Requires longer length of stay, comparable benefit only in certain OCD symptom dimensions
- More severe contamination symptoms
- Increased rate of comorbid disorder (e.g., substance use disorder, personality disorder, trauma-related disorders)

(Pinciotti et al., 2022)

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Misidentification by professionals

Intrinsic Factors	Clinician Factors	Patient Factors / Stigma
OCD: • Difficulties with diagnosis of doubt-based obsessions • Further difficulties in the diagnosis of doubt-based sexual/gender-themed obsessions • Avoidance and need to conceal **Gender incongruence:** • Evolving understanding and complexity	**OCD:** • Reluctance to obtain shame/taboo-themed history **Gender incongruence:** • Professional training, personal experiences and beliefs providing negative bias against gender incongruent individuals • Lack of training on sex and gender • Professionals seeking to foster a therapeutic alliance with parents / payors	**OCD:** • Fear of revealing gender doubting thoughts due to shame and fear of misunderstanding **Gender incongruence:** • Fear of discrimination if gender incongruence and desire to transition to a gender not assigned at birth is revealed

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Misidentification by professionals

Diagnostic difficulties in OCD

- Professionals are more likely to have difficulty identifying sexual (and by extension gender) themed obsessions due to difficulties with diagnosis of doubt-based OCD
- Even seasoned clinicians may struggle with a diagnosis of doubt-based OCD

(Aboujaoude & Starcevic, 2021)

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Misidentification by professionals

Clinician bias

- Some clinicians believe that gender identity is a social construct prone to easy influence
- Nonfactual beliefs that gender identity can be externally reversed
- Studies have shown a persistence of gender identity in majority of cases

(Safer et al. 2016, Safer & Tangpricha 2008, Steensma et al. 2013)

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Misidentification by professionals

Stigma sources

- Gender OCD patients reporting intrusive thoughts of doubting their gender (whether assigned = identified or assigned ≠ identified)
- Clinicians inquiring about taboo-type thoughts leading to reluctance to obtain more history about such stigmatized thoughts
- Gender incongruent patients fearing social / cultural discrimination and violence due to identifying with a gender other than one assigned to them at birth
- Clinicians perpetuating gender stigma with behavior that is transphobic or discriminatory against gender incongruent patients

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Misidentification by professionals

Misidentification of gender OCD for *DSM-5* gender dysphoria leads to negative consequences including treatment delay, potential worsening in symptom severity and further stigmatization

Misidentification of gender incongruence for *DSM-5* gender dysphoria for gender OCD may lead to grave consequences in a very vulnerable population with higher rates of depression and suicidal ideation and attempts

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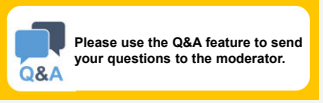
Differential and diagnosis



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Sexual orientation development

Sexual orientation identity development theories

- Uncertainty part of normative development (both heterosexual and sexual minorities)
  - Reflect normal curiosity and exploration (e.g., sexual experimentation, reflection of attraction and fantasies)
  - Can be experienced as distressing, potentially adverse reaction to being part of highly stigmatized minority group

(Hollander, 2000)

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Sexual orientation development

Higher sexual orientation uncertainty

- Associated with increased depressive symptoms, stress, and rumination (both heterosexual and sexual minorities)
- Predicted aggression in only sexual minorities (recent instance of physical and verbal aggression, increased anger and hostility)
  - May be related to fear of or experiences of discrimination
- Rumination common maladaptive coping strategy
  - In only sexual minorities, rumination mediated sexual orientation uncertainty and psychological distress

(Borders et al., 2014)

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Gender identity development

Gender dysphoria manifests in early childhood
(Zaliznyak et al., 2020)

Stages of development:
(Devor, 2004; Hiestand & Levitt, 2005)

- Anxiety (gender discomfort)
- Confusion (doubts of biological gender, doubts of authenticity of transgenderism)
- Exploration (testing transgender identity)
- Acceptance (acceptance of identity)
- Pride

Gender identity misclassification > negative emotions and threat
(Swann 1997, 2011)

Gender identity affirmation > in control, decreased anxiety and depression

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Assessment

Background assessment	Yale-Brown Obsessive Compulsive Scale (Y-BOCS) or CY-BOCS (child version)	Ego-dystonic vs Ego-syntonic
• Family values, dynamics, relationships • Cultural background • Social network • Religious/spiritual views	• Uncertainty and distress can be present in both normative development and OCD • Assess for severity of distress and impairment • Presence of other OCD symptoms (lifetime or current)	• **Normative:** Thoughts of affirming gender or being with same sex individual may provide some comfort or relief • **OCD:** Doubts are not accompanied by positive experiences or affect, marked by ego-dystonic distress and related compulsive behaviors

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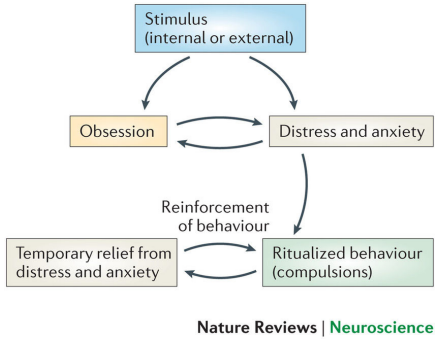
Assessment – CBT Case Conceptualization

- Complete functional analysis
  - Situation/trigger (A)
  - Thoughts/beliefs
  - Emotions/sensations
  - Behavioral responses (B)
  - Consequences (C)
- Does clinical presentation map onto CBT model of OCD?
- Utilize downward arrow method to identify core fears

(Pauls et al.,2014)



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Assessment – SORT

Sexual Orientation Obsessions and Reactions Test (SORT)

- 12 items, self report measure
- Responses 0 (never) to 4 (always)
- Good psychometric properties
- Cut off score of 10 to differentiate between OCD and non-OCD
- Cut off score of 14 within OCD (differentiating SO-OCD from other subtypes)

(Williams et al., 2018)

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Assessment – SORT

Transformation fears

- I worry about the thoughts I am having about people of the same sex
- I just need to know for sure if I am straight
- I worry that other people will think I am LGBTQ

Somatic checking

- I check myself to see if I am aroused by sexual images
- An unwanted sexual thought or image means I really want to do it

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Treatment

Q&A Please use the Q&A feature to send your questions to the moderator.

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Overview: Pharmacotherapy for OCD

- Systematic reviews and network meta-analyses have shown that both CBT/ERP and serotonin modulating medications are effective in management of OCD:
  - Selective Serotonin Reuptake Inhibitors (SSRIs)
  - Clomipramine
- Clomipramine OR SSRIs > placebo
- Augmentation strategies
  - First line – dopamine blockers (i.e., antipsychotics)
  - Others: clomipramine, glutamate modulators

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Overview: CBT for OCD

- Incomplete responders to pharmacotherapy
  (Simpson et al. 2008)
  - Most patients who have received an adequate SSRI trial continue to have clinically significant OCD symptoms.
  - ERP is superior to stress management training in reducing OCD symptoms in patients continuing SSRI therapy
- ERP add-on to medications: success and timing
  (Tennejj et al. 2005)
  - ERP / behavioral therapy is a successful add-on to OCD patients with partial response to pharmacologic treatment.
  - Greater effect when ERP added immediately after drug response.

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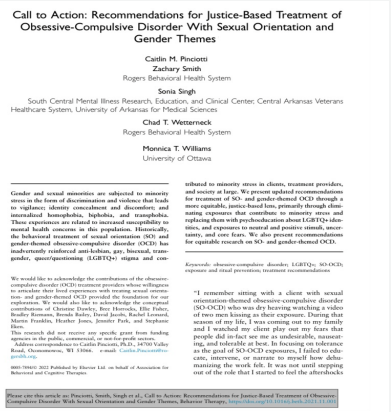
E/RP for SO-OCD and Gender Identity OCD

- Seminal article delineating justice-based application of exposure-response prevention
- Move away from exposures that reinforce stigma or stereotypes
  - Act “gay”
  - Speak in a lisp
  - Wear “girly colors”
  - Do “girly things”



Call to Action: Recommendations for Justice-Based Treatment of Obsessive-Compulsive Disorder With Sexual Orientation and Gender Themes

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Developing exposures

Does this exposure tokenize or “out” people?

Does this exposure reinforce stereotypes or add minority stress?

Does this exposure ignore historical trauma?

Can you make this exposure a different way and achieve the same result?

Can this exposure be made about appreciation/celebration over tolerance of a community?

Would this exposure need to be clarified to peers/others?

Would you feel comfortable doing this exposure in front of someone who had this identity/trait?

(taken from Pinciotti et al., 2022)

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Case example: Emily

A: Adolescent, 16 years old
D: Anxiety, Depression
D: Able-bodied
R: Christian
E: Chinese-American, Asian
S: Heterosexual
S: Middle class
I: Non-native
N: US born
G: Cisgender

Emily presents with complaints about “obsessive“ thoughts about being transgender. She notes that these thoughts are easily triggered: looking in the mirror when changing, taking a shower, social media or news that have topics of transgender or gender fluid individuals, seeing a female with short hair, seeing a male with long hair. She noted that she first started having these symptoms 2 years ago after seeing an ad for the show Pose, which highlights transgender characters and actors. These symptoms increased in intensity over time and Emily rates her distress as 10 out of 10 when she has these thoughts. Emily frequently asks her parents to describe how she was as a child – Emily noted that she does this to check to see if she ever acted like a boy when she was younger. She also analyzes pictures of herself in elementary school to see if she can remember whether she thought of herself as a boy when she was a child.

Emily notes that her social community is progressive and inclusive and that she does not have any personal negative views towards the transgender community. She stated that her uncle is gay and is accepted by the family, but also notes that she is not sure if her family would be accepting of a transgender family member as she is worried that being transgender may be considered “too different.”

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Functional analysis

Situation or Trigger	Thoughts and/or beliefs	Emotions	Behavioral Responses	Consequences
• See body in mirror while changing	• Am I supposed to be a man? • Because I had that thought I must be transgender	• Increased anxiety, distress and upset	• Ask parents "Did I always act and play like a girl when I was a kid?", Parents say "Yes" and provide examples	• Anxiety and distress decreases

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Identifying core fear

Downward arrow method

- Would I feel better in a male body?
- Because I had that thought, it must mean that I'm transgender
- If I don't know if I'm supposed to be a man or woman, then what do I even know
- Everything I ever knew about myself must be a lie
- I don't know who I am anymore, I can't trust anything about myself

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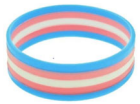
Exposures

- Watch trans-affirming movies or television shows
- Hang transgender flag in room
- Wear bracelet or t-shirt with transgender flag colors (blue, pink, white)



- Visit and take educational courses at LGBTQ+ community center (e.g., Rainbow Center)
- Conduct imaginal exposures related to never feeling certain about gender identity

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Time for questions and answers…

- Please use the Q&A button – not the chat – to submit your question
- If we don't get to your question, please feel free to send an email to **webinars@rogersbh.org** and we will follow-up with you

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Additional information

International OCD Foundation
"From the experts" section: https://iocdf.org/expert-opinions/

Anxiety and Depression Association of America
"LGBTQ+ Community" section: https://adaa.org/find-help/by-demographics/lgbtq

American Psychiatric Association
A Guide for Working With Transgender and Gender Nonconforming Patients: https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients

Family Acceptance Project® at San Francisco State University
Publications and resource materials: https://familyproject.sfsu.edu/publications
Resource website for LGBTQ youth and family: https://lgbtqfamilyacceptance.org/

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About the presenters….

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