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Sylwia Michałowska

SEXUAL ORIENTATION OBSESSIVE-COMPULSIVE DISORDER IN COGNITIVE-BEHAVIOURAL THERAPY – A CASE STUDY

Institute of Psychology, University of Szczecin

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Summary

Obsessive-compulsive disorder (OCD) is a diagnosis that is heavily stereotyped in the public sphere, often associated with fears of germs and contamination, which are countered by excessive hygiene, avoidance, and compulsive hand washing. However, do patients visiting psychiatric and psychotherapeutic offices present a different picture of this disorder in reality? Practice shows that the spectrum of symptoms is extremely broad, and a thorough understanding of these symptoms allows for an accurate diagnosis and the application of effective therapeutic interventions that reduce the patient's real suffering. The aim of this study is to demonstrate the application of cognitive-behavioural therapy (CBT) in treating a patient diagnosed with OCD related to sexual orientation. The method involved the description and conceptualisation of the case of a 36-year-old female patient and the process of psychotherapy based on exposure and response prevention. The therapeutic techniques used, and the effects achieved through them are described. Although further research involving the indicated group of patients is necessary, attention should be drawn to the possibilities and opportunities offered by a method that has been thoroughly proven effective in treating other forms of OCD.

Introduction

Obsessive-compulsive disorder in clinical practice

Obsessive-compulsive disorder (OCD) is associated with the occurrence of difficult, intrusive thoughts, impulses or images, perceived by the patient as unwanted, egodystonic, referred to as obsessions [1]. In order to reduce fear, anxiety and tension related to the content of the obsession, the patient takes actions aimed at neutralizing them, e.g., by avoiding, making sure about specific obsessive doubts related to the disorder and checking or performing rituals and patterns of action, called compulsions [1]. They may take the form of overt behavior, visible to an external observer, but it is also worth remembering about the occurrence of mental compulsions, carried out in the patient's mind, invisible in observation. They are examples of implicit coping strategies. Research indicates that

one of the most common implicit strategies typical of OCD patients is thought suppression [2]. When suppression fails, patients assume that the cause is internal factors, e.g., they are convinced that they did not try hard enough to stop the obsession [3, 4]. A study focused on determining the frequency of mental rituals in a sample of almost a thousand OCD patients showed their presence in over 50% of participants, which suggests that they are quite common [5]. Longitudinal analyses assessing the impact of mental rituals on the severity and chronicity of OCD confirmed their relationship with greater severity of clinical symptoms, worse functioning at the time of admission and the chronic course of the disease (treatment lasted on average 1 year longer than in the case of patients without mental compulsions) [6]. Given these conclusions, it seems extremely important to take into account the occurrence of mental compulsions in the diagnosis and to introduce strategies in therapy aimed at extinguishing them.

According to modern knowledge about the etiology of OCD, neurobiological components, including genetics, should be considered the causes of obsessive-compulsive disorder. The concordance rate for symptoms of the disorder in identical twins ranges from 20% to 50% [7]. The probability of OCD occurring in a person related to another diagnosed person is between 45% and 65% in children and between 27% and 45% in adults [8]. Researchers also point to the importance of structural and functional brain anomalies in the orbitofrontal cortex, anterior cingulate cortex and striatum [9]. In understanding the disorder, attention is also paid to possible serotonin deficits or difficulties in its metabolism [10]. However, we currently do not have full knowledge about the causes of OCD.

Obsessive-compulsive disorder can come in many different types. However, its symptoms always cause significant suffering for the patient, even if he or she assesses their content as irrational or unlikely. A special type of obsessive-compulsive disorder is one in which the symptoms focus on sexual orientation (sexual orientation obsessive-compulsive disorder, SO-OCD). In the disorder, we observe obsessive, difficult-to-bear thoughts and doubts about one's sexual orientation, as well as compulsive activities (including mental ones) that reduce anxiety and discomfort. Intrusions regarding sexual orientation are ego-dystonic for patients with SO-OCD, combined with fear and anxiety, and their direct connection with compulsive and avoidant behaviors distinguishes this type of disorder from the process of questioning one's sexuality. The repertoire of behaviors includes, among others: avoiding being in the presence of specific people, checking whether sexual arousal occurs in specific intimate relationships. Avoidance and performing rituals temporarily reduce anxiety, contributing to the classic mechanism of perpetuating the disorder. Importantly, in patients with SO-OCD, the experience of anxiety is not related to fears of rejection or lack of acceptance from loved ones [11], and the burdensome thoughts themselves are largely related to the difficulty in tolerating uncertainty and the fear of making a mistake ("what if I was mistaken about my own orientation?"), characteristic of obsessive-compulsive disorder. In the diagnostic context, this distinction is important because many people with SO-OCD are wrongly diagnosed as "experiencing a sexual identity crisis" [12]. For specialists, the use of questionnaires aimed at assessing SO-OCD symptoms may be helpful in diagnosis. An example of such a tool is the Sexual Orientation Obsessive-Compulsive

Scale [13] with good psychometric properties for the Italian version. Unfortunately, this questionnaire has not been validated in Poland yet.

Cognitive-behavioral understanding of obsessive-compulsive disorder

In the cognitive-behavioral modality, therapists refer to theoretical models when conceptualizing the patient's difficulties. There are many cognitive theoretical models of OCD. These include the following: the model of Carr [14], McFall and Wollersheim [15], Salkovskis [16], Rachman [17], Wells [18] and the model of Van Oudheusden and colleagues [19].

Carr's model [14] was the first cognitive attempt to conceptualize patients with OCD. It highlighted primarily threatening interpretations given to intrusive cognitive content, occurring in combination with a general high sense of threat. According to the author, this combination results in overestimating the probability of undesirable events and negative consequences. An extension of the model is the work of McFall and Wollersheim [15], in which it was noted that the sense of threat characteristic of people with OCD is the result of a primary cognitive assessment in which the patient perceives a given event as threatening and himself as a person who lacks resources and abilities to cope. Anxiety in patients with OCD increases because of the primary assessment, while the assessment of possible consequences leads to compulsions. The patient engages in compulsive actions to prevent the anticipated disaster.

According to the cognitive-behavioral model of OCD proposed by Salkovskis [16], patients with obsessive-compulsive disorder make many dysfunctional assumptions that maintain the symptoms and need to be taken into account in the therapy process. These include:

1. The belief that having specific thoughts is equivalent to performing actions consistent with these thoughts (e.g., thinking that you are homosexual is tantamount to being homosexual).
2. The belief that failure to prevent negative events is tantamount to causing them (e.g., "if I failed to prevent someone of the same sex from hugging me, I am guilty of causing this situation").
3. The belief that other factors do not mitigate responsibility (e.g., "even if I went to a place where I never had to be alone with someone of the same sex, but it happened once, I am responsible for it").
4. The belief that failure to perform rituals is tantamount to an attempt or desire to bring about negative events (e.g., "if I have not repeated the words 'I am not a lesbian' three times in my mind, it means that I want to be one").
5. The belief that you can and should control your thoughts (e.g., "if I try hard not to have thoughts about being a lesbian, I won't have them").

In the context of obsessive-compulsive disorder related to sexual orientation, Rachman's model [17] also deserves attention, according to which patients suffer because they fuse thoughts with actions, assuming that thinking about something is equivalent to doing it. Ac-

cording to this approach, thinking about one's own different sexual orientation or emerging doubts in this regard are identified as confirmation and sanction of the experienced fears. The person then assumes that he or she has a different orientation than the one previously recognized and practiced, and this causes suffering. Therefore, the patient increases his efforts to check his actual orientation, for example, by watching pornographic films and verifying whether he is interested in them or aroused. It is also possible to use avoidance (e.g., trying to reduce any interactions with people of the same sex in the case of concerns about homosexual orientation) or seeking reassurance from others (e.g., trying to confirm one's sexuality by increasing the number or frequency of sexual contacts).

It should be clearly stated that SO-OCD is different from natural, temporary or developmental doubts and thoughts about one's sexuality and orientation. This difference is primarily related to the lack of sexual interest that would be consistent with the fears. However, during the diagnosis process, it is necessary to verify the nature of the patient's concerns and identify the functions of the neutralizing behaviors undertaken. It is also worth paying attention to the time criterion. In obsessive-compulsive disorder, what is diagnostic is not the appearance of episodic thoughts themselves, but the importance given to them, the discomfort associated with their content, and the time devoted to analyzing these thoughts and behaviors related to them (checking, reassurance, avoidance, etc.). Typically, SO-OCD affects heterosexual people who do not feel attracted to people of the same sex, but are tormented by obsessive thoughts that they may be homosexual after all (even though there is no indication of this) [20]. It is worth paying attention to whether the features of intrusive thoughts and the interpretations related to them are consistent with the presented theories. In the case of SO-OCD, a patient who has doubts about sexual orientation overestimates the threat associated with these thoughts, feels responsible for their appearance and shows excessive thought control [21]. This is not related to hostility or hatred towards homosexual people [20]. According to the conclusions of previous research, patients who struggle with concerns about their sexual orientation present black and white beliefs about sexuality, e.g., “a heterosexual woman should never feel aroused in the presence of another woman”, which causes anxiety when these high and rigid standards are not met and there is a compulsion to neutralize the discomfort [20].

Wells' theoretical model [18] considers the metacognitive aspect of the disorder, i.e., giving meaning to one's intrusive thoughts. However, in the model of Van Oudheusden and colleagues [19], the relationship between the sense of limitation of voluntariness of actions and the compulsion to perform actions should also be considered.

Importantly, the appearance of difficult, intrusive thoughts is quite common in the population, which is why contemporary theoretical models focus primarily on the threatening interpretation and meaning that OCD patients give to their thoughts. When developing symptoms of the disorder, they perceive the emerging thoughts or images as extremely significant or dangerous [22]. The synthesis of cognitive and behavioral elements in the conceptualization of patients diagnosed with OCD can be seen below:

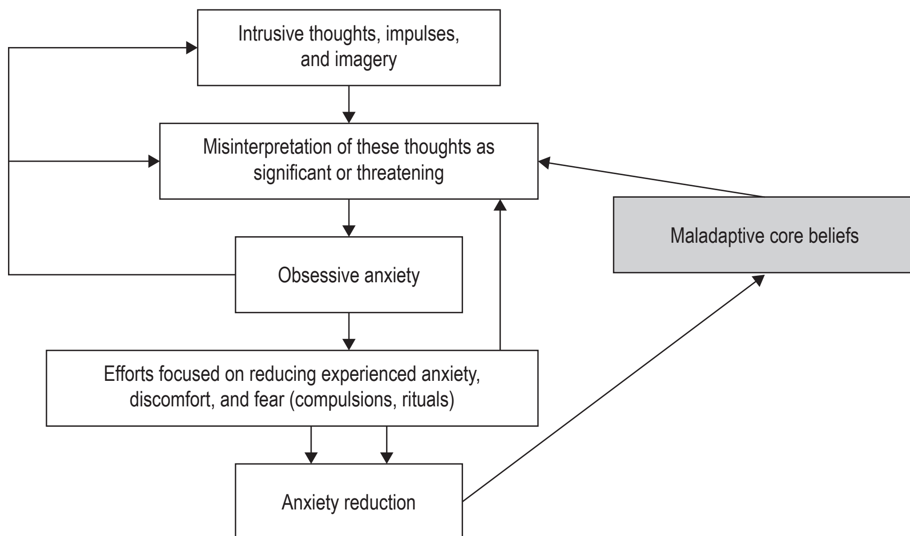

Figure 1. **Cognitive-behavioral model of OCD**

Source: Based on Abramowitz [23].

According to the presented model, a temporary reduction in fear and anxiety confirms the patient's core and maladaptive beliefs, leading to the consolidation of the pattern of compulsive behavior. The problem is that the temporary reduction in discomfort resulting from performing compulsions prevents the patient not only from falsifying beliefs, but also from learning to tolerate discomfort [24–26], which, when experiencing the obsession again, strengthens the compulsion to perform a specific activity and perpetuates the vicious circle mechanism.

Considering the relationship between the occurrence of obsessive thoughts and assigning them significant meaning and undertaking compulsive activities that intensify the presence of these thoughts, a therapeutic protocol based on exposure with reaction inhibition was developed, helping to break the vicious circle and reduce symptoms [27]. There is abundant empirical evidence showing the effectiveness and validity of using this approach in OCD psychotherapy, which is confirmed by the recommendations of institutions such as the American Psychological Association (APA) [28] and the National Institute for Health and Care Excellence (NICE) [29]. Research on the use of individual cognitive-behavioral psychotherapy in the treatment of OCD has shown that this method contributes to the reduction of symptoms [30, 31]. Exposure with reaction inhibition is important in this process, and the development of modern technologies and contemporary research reports suggest that this technique may be developed and improved in the future [32].

This paper presents a conceptualization of the case of a patient diagnosed with SO-OCD and a description of the cognitive-behavioral psychotherapy conducted and the effects obtained.

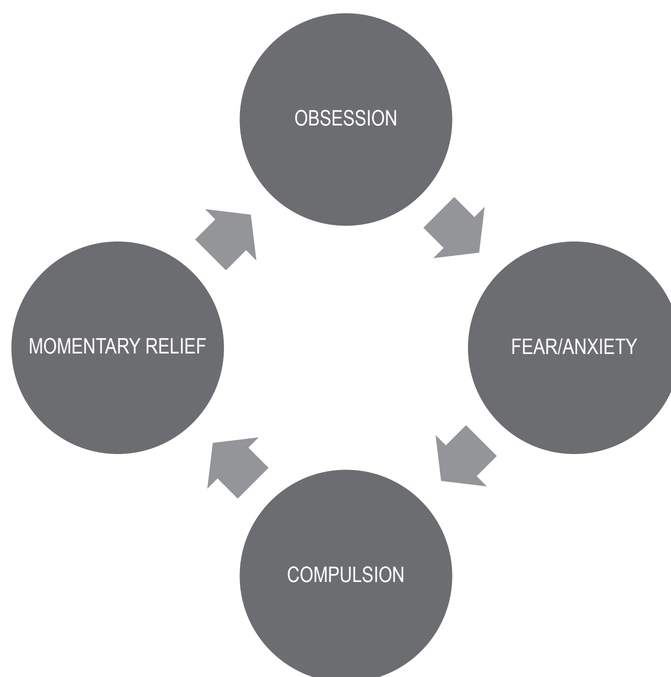

Figure 2. **The vicious circle of OCD**

Source: Self-prepared

Case description and conceptualization

Mrs. X – introductory information and life story

The patient is 36 years old and has higher education. She has been in a relationship for 10 years and married for 7 years. She got married in a Catholic ceremony. She is the mother of a 5-year-old girl. Professionally active. She comes from a Catholic family, very involved in religious practices, she also regularly attends services and declares her religion to be the same as her parents'. The patient's family pays great attention to leading a life consistent with values such as truth, honesty, loyalty and modesty. The indicated values are equally important for the patient and she tries to practice them in everyday life. The patient has always been a very conscientious person for whom a sense of responsibility was the basis of her self-image. Even as a child, Mrs. X made sure not to be late, to make her parents proud, not to break the rules, and to receive good grades in academics and behavior. She was praised for this attitude by both her parents and her family environment. The patient always completes all her duties on time and devotes a lot of attention to them, she does not tolerate mistakes in her work, even if the performance of a task requires her to devote her free time. She also feels responsible for the functionality of the entire family – she always prepares

healthy meals herself, reads product labels when shopping, knows exactly her husband's work schedule, meticulously plans joint activities (checks dates, times, transport connections, makes reservations, concludes insurance contracts, etc.). Mrs. X has a brother who is 6 years younger. She maintains a good relationship with him.

The patient was born at term, from a normal pregnancy. She has never been hospitalized, diagnosed psychiatrically or treated for mental health disorders. Family members have never received psychiatric treatment. Mrs. X did not repeat classes, she was a good and popular student. She has friends from her university days. She describes her family and social relationships as good. Professional and family life is a source of satisfaction and fulfillment for the patient. The patient denies the presence of somatic diseases and declares good general health. There were no potentially traumatic events identified in her life history.

Diagnosis

The patient came for a psychotherapeutic consultation due to experiencing intense and unpleasant thoughts, causing low mood and related to the need to avoid specific circumstances, situations and behaviors. At the time of reporting, these symptoms had been present for approximately one year. The indicated thoughts and related reactions, according to the patient's estimates, occupied about 2 hours every day, with periodic exacerbations. The moment when the symptoms appeared was when the patient met her brother's current fiancée and spent a lot of time with her. Then she noticed how attractive her future sister-in-law (Ms. Y) was. This was associated with the occurrence of sudden, intrusive thoughts such as "why do I think so much about her appearance?", "why do I like her so much?", "am I a lesbian?", "what if I'm homosexual?". The patient assessed her thoughts as very significant, and at the same time they were associated with the experience of intense anxiety and discomfort. Mrs. X tried to reduce her discomfort by avoiding the company of her future sister-in-law, sitting as far away from her as possible during gatherings, engaging in conversations with her husband in which she deliberately described the visual flaws and character weaknesses of her future sister-in-law, and repeatedly thinking to herself the phrase "I am not a lesbian," initially once, and then from 3 to 9 times. As a result of the interview, based on the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) classification criteria, the patient was diagnosed with obsessive-compulsive disorder with the following symptoms:

1. The occurrence of obsessive, intrusive thoughts about the possibility of being a person of homosexual orientation.
2. The occurrence of compulsive overt and covert (mental) behaviors aimed at reducing anxiety, fear and discomfort, such as checking, comforting (in thoughts) and avoidance.
3. Engaging in focusing on obsessive thoughts and compulsive activities (analyzing, checking, avoiding, neutralizing, rituals), consuming 2 to 4 hours each day.
4. Experiencing significant suffering associated with low mood, feelings of sadness and shame, affecting the patient's daily functioning – distractibility, withdrawal from the relationship with her husband, problems with sleep.

Mrs. X showed satisfactory insight into her symptoms. Most of the time, she was aware of the irrationality of her fears and was highly motivated to seek treatment.

Cognitive model of the patient's basic diagnosis

Taking into account the theoretical models described in the cognitive-behavioral approach, the case was conceptualized. It was assumed, in accordance with the model of Salkovskis [16] and Rachman [17], that the patient interprets the occurrence of intrusive thoughts as an indication/evidence that they describe reality (fusion of thoughts and actions) and that she will be responsible for their possible negative consequences (family breakdown, hurting her husband, suffering of her daughter, disappointing her parents), unless she takes action that can prevent it (she will avoid the woman who arouses interest, diminish her strengths, or comfort/convince herself that she is not a lesbian, she will successively suppress disturbing thoughts). Reactions aimed at reducing the sense of responsibility and discomfort maintain the patient's beliefs. The recurrence of intrusive thoughts then becomes even more likely. Mrs. X's efforts to neutralize her thoughts lead to the development of rituals, which are actions that reduce her sense of responsibility, temporarily lowering her anxiety. As a result of using these rituals, the frequency of intrusive thoughts increases, heightening the need for neutralizing behaviors. This, in turn, perpetuates the symptoms. The patient begins to avoid situations involving the risk of interest in other women, seeks reassurance (that she is not a lesbian) from loved ones, or tries to extinguish intrusive thoughts. The consequence is the maintenance of symptoms by developing new rituals (e.g., comforting oneself with thoughts, increasing the number of repetitions) and increasing the level of anxiety [33]. Mrs. X, as a person brought up in a family for which values such as truth and honesty were highly valued, internalized the indicated values. When difficult, obsessive thoughts appeared, they were interpreted as dangerous because they threatened the stability of the self-image in which the indicated values are not only highly valued, but also conscientiously practiced. Consequently, the anxiety and discomfort associated with the experienced thoughts were assessed by Mrs. X as unbearable. When compulsive behaviors provided even temporary relief, these activities perpetuated themselves in a vicious circle. Additionally, the patient's strong sense of responsibility motivated her to take actions aimed at preventing the potential misfortune that would result from the confirmation of her obsessive fears.

Figure 3. **Mrs. X’s content in the vicious circle of OCD**

Source: Self-prepared

Core and intermediate beliefs of the patient, as well as coping strategies

Beliefs and specific cognitive distortions played an important role in the development and consolidation of Mrs. X’s obsessive-compulsive disorder. The leading one is dichotomous thinking, reflected in perceiving situations in extreme categories, e.g., one mistake cancels out all efforts. The patient’s cognitive content also includes magical thinking, based on the belief that there is a logical cause-and-effect relationship between accidental circumstances, e.g., the assumption that if she repeats in her mind “I am not a lesbian” three times, she is not a lesbian.

The patient’s conceptualization, which should also take into account core and intermediate beliefs, expands the understanding of the sources of OCD and the aspects that made Mrs. X sensitive to the occurrence of the disorder. The patient’s basic, rigid belief is most likely “I am sinful”, the source of which are rigid patterns of morality and religiosity combined with a sense of significant responsibility for the happiness and fulfillment not only of her own, but also of the family. Thinking about another woman in a sinful way (“she is attractive”), according to Rachman’s model [17], is tantamount to committing sinful acts (fusion of thoughts and actions), which is associated with a feeling of tension and forces

the use of neutralization in the form of avoidance ("I don't talk to other women <alone>") and rituals ("I repeat in my mind 3, 6 or 9 times <I am not a lesbian>").

Table 1. **Mrs. X's beliefs and coping strategies**

Intrusion	Interpretation	Intermediate belief	Core belief	Neutralization
She is pretty	What kind of wife am I if I think this way about another woman?	If I like other women, then I am a sinner	I am sinful	Avoidance: I stop talking to my sister-in-law Ritual: I repeat in my mind 3 times "I am not a lesbian"

Source: Own work based on Bryńska [33].

In the area of beliefs about the world and other people, cognitive content such as "Other people are demanding and critical", "The world is full of bad things" can be distinguished. The aspects described above, on the one hand, made the patient susceptible to the development of obsessive-compulsive disorder, and on the other hand, they perpetuated the mechanism of a vicious circle. A graphical summary of the patient's conceptualization in theoretical models is presented in Figures 4 and 5.

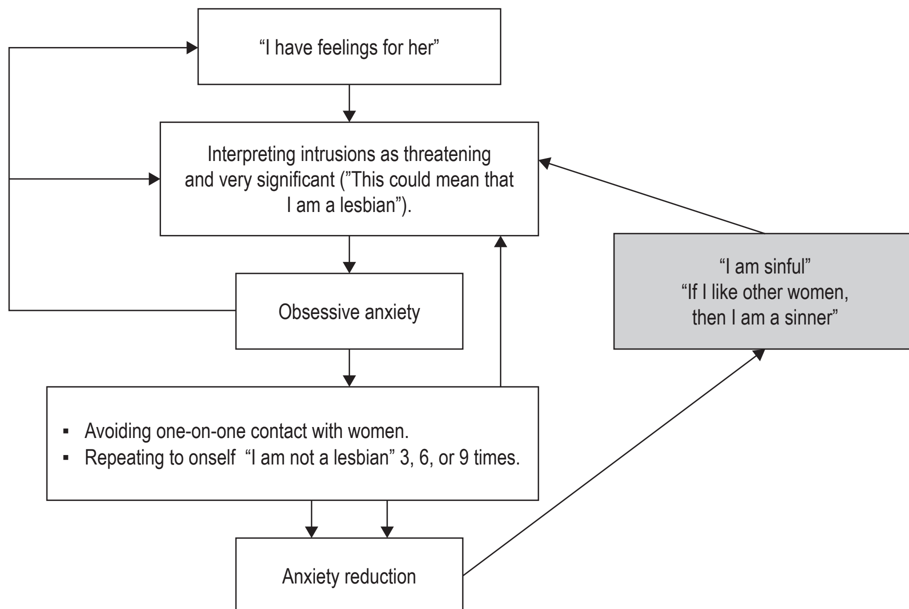

Figure 4. **Cognitive content of the patient in Abramowitz's theoretical model**

Source: Own work, based on Abramowitz, 2009 [23].

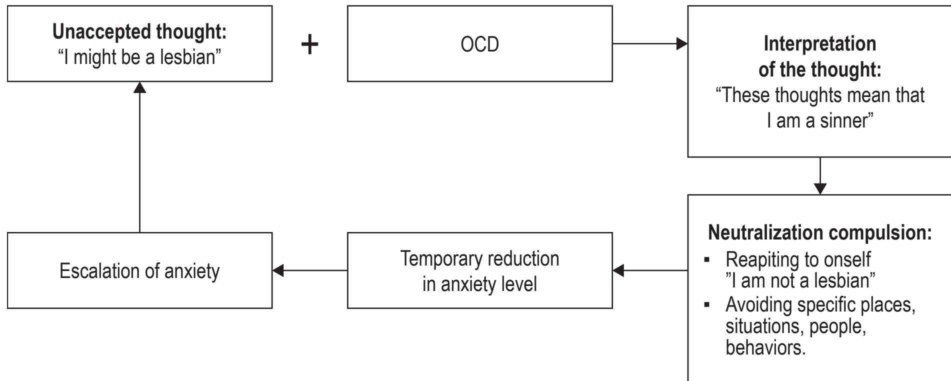

Figure 5. **Cognitive content of the patient in Salkovskis's theoretical model**

Source: Own work, based on Salkovskis, 1985 [16].

The summary of the conceptualization is illustrated in the diagram below.

Early experiences contributing to the formation of core beliefs: High and rigid moral standards of the family Rewarding responsibility for oneself and others Internalized significance of morality and self-control	
Key belief: "I am sinful"	
Intermediate belief: "If I am attracted to other women, then I am sinful"	
Coping strategy for the belief: Avoidance (of contact, relationships, sinful thoughts, threatening circumstances)	
Situation: The future sister-in-law tries to hug the patient	**Situation:** The patient accidentally looks at a nearly naked woman in a sports locker room
Thought: "Do I look like a lesbian?"	**Thought:** "She must think I'm a lesbian"
Emotion: anxiety	**Emotion:** anxiety, anger
Behavior: The patient quickly exits to the bathroom.	**Behavior:** The patient looks at the ground and repeats to herself three times, "I am not a lesbian."

Source: Self-prepared

Therapy process

The patient did not choose to implement pharmacotherapy but, as recommended, she underwent a psychiatric consultation, during which the diagnosis of SO-OCD was confirmed. In agreement with Mrs. X, therapeutic goals were formulated. A treatment plan was developed and presented to the patient based on the adopted therapeutic protocol recommended for treating patients with an OCD diagnosis. The treatment protocol used was authored by Foa, Yadin, and Lichner [34] and is based on exposure with response prevention. The adopted method of work provides for the use of two types of exposure (i.e., exposing oneself to experiencing discomfort that the patient is afraid of): imaginal (realized in the mind, in the form of ideas) and in vivo (in life, realized in reality). The indicated exposures are part of the session (they are carried out in the office or outside it as part of a meeting with the therapist) and an element of the so-called personal work, i.e., tasks to be completed by the patient between sessions, which are planned together and then discussed during meetings. During the exposure, the patient completes self-observation forms, which constitute a record of his/her own practice and enable the assessment of the severity of symptoms and monitoring the effectiveness of the therapy. The exposures are carried out based on the so-called hierarchy, i.e., ordering of e.g., behaviors related to OCD and necessary to be reduced, along with the assessment of the Subjective Units of Discomfort/Distress Scale (SUDS). Referring to SUDS allows one to estimate how significant a challenge it is for the patient to refrain from a specific behavior or to feel the need to avoid a particular situation. The higher the SUDS level, the higher the patient's discomfort in the indicated circumstances.

Table 2. **OCD treatment protocol: exposure with response prevention**

Session1	Session 2	Session 3	Session 4	Intermediate Sessions	Final Session
Preliminary information on the nature of symptoms and the history of the disorder	Discussion of the self-monitoring form	Discussion of the self-monitoring forms and insights from the guide	Discussion of the self-monitoring forms	Evaluation of self-monitoring and personal work, conclusions	Assessment of progress
Psychoeducation — What is OCD?	Gathering detailed information about the symptoms	Creation of an exposure hierarchy	Discussion of personal work, conclusions	Conducting in vivo exposure and discussing it cognitively	Preparation for returning to daily activities
Presentation of the rationale for therapy and the therapeutic program	Assessment of symptoms using the distress scale and creation of an exposure hierarchy	Conducting in vivo exposure	Discussion of imaginal exposure	Conducting imaginal exposure and discussing it cognitively	Discussion of relapse prevention. Termination of therapy
Explanation of what self-monitoring entails	Development of the therapy program	Guidelines for self-conducted exposure	Conducting in vivo exposure	Assessment of progress	

table continued on the next page

	Establishment of the therapeutic contract	Introduction to the principles of response prevention	Providing guidelines for self-conducted exposure	Personal work — self-monitoring, exposures, SUDS assessment, psychoeducation	
	Assignment of personal work — self-monitoring, reading the guide	Personal work — conducting in vivo exposure with response prevention, reading about its principles, and using the self-monitoring form	Personal work — conducting in vivo exposure and evaluating the level of distress using the SUDS scale in the form, self-monitoring		

Source: Modified based on Foa, Yadin, Lichner [34].

In Mrs. X's therapy process, both imaginal and in vivo exposure were used in the office, and exposure tasks were planned for the patient to complete as personal work between sessions. Due to the specific nature of the symptoms, it was necessary to expand Foa's protocol [34] with techniques proposed by Hershfield and Corboy [35] for patients with OCD related to sexual orientation. Therefore, visual exposures were conducted, such as viewing objects that triggered undesirable thoughts (e.g., photos of Ms. Y) while refraining from performing mental rituals. Imaginal exposures were also carried out, such as the idea of coming out or looking for a female partner. The justification for the use of imaginal exposures in the indicated areas was the specificity of the patient's concerns. The exposures used are presented in Table 3. According to the recommendations of Hershfield and Corboy [35], visual exposures, as well as imaginal ones, supported the confrontation with the trigger and provided the patient with the opportunity to refrain from compulsions as part of the training in the office and between sessions, with high frequency (exposure with response prevention practice took place every day).

Table 3. **Exposures used in Mrs. X's therapy**

Example of exposure-based exercise	Type of exposure
Experience of the reactions of close ones to the patient's coming out	Imaginal exposure
Scenario of a first homosexual date	Imaginal exposure
Viewing photos from Ms. Y's vacation	Visual exposure
Watching videos of women kissing	Visual exposure
One-on-one conversation with an attractive woman	Situational exposure
Visiting a bar popular among homosexual individuals	Situational exposure

Source: Own work

During the exposure, stopping mental rituals was used by instructing the patient on the need to inform the therapist about the moment the ritual occurred and blocking it using the word "STOP". The conducted exercises were combined with cognitive work addressing Mrs. X's beliefs, aiming to restructure her understanding of the significance attributed to her own thoughts and catastrophic predictions about refraining from compulsions. The patient feared that if she stopped performing neutralizing activities, the intensity and frequency of her thoughts would increase, leading to a worsening of her symptoms. The goal of belief restructuring involved exposure and discussion based on an exposure hierarchy constructed during the session, with SUDS assessment.

Table 4. **Hierarchy of exposure for patient X**

Situation	SUDS level
Touching Ms. Y	90
Sitting next to Ms. Y	85
Being in the women's locker room after a fitness class	75
Talking to Ms. Y with her husband present	70
Kissing her husband	60
Seeing homosexual women	55

Source: Own work

During the therapy process, numerous exposure hierarchies were created and based on them, imaginal and in vivo exposures were conducted along with discussion. The patient regularly practiced exposure with response prevention and overcame avoiding situations that caused discomfort, e.g., staying in the women's locker room after fitness classes. The imaginal exposures used also included imagining the moment when the patient informed her family that she was homosexual, or the course of the first homosexual date. Exposures were carried out from lower to higher levels of SUDS, while paying attention to the patient's experiences. During the therapy process, SUDS units were evaluated and the change achieved was monitored, as presented in Table 5.

Table 5. **Evaluation of SUDS units during therapy**

Exposure example	SUDS at the beginning of therapy	SUDS after 10th session	SUDS after 20th session	SUDS after 30th session
Looking at Ms. Y's vacation photos	70	60	35	10
Watching videos of women kissing	85	70	50	30
Staying in the women's locker room after fitness classes	75	60	45	20
Imagining your lesbian date	60	55	40	20

Source: Own work

After the exposure, a distraction conversation was conducted during the session in order to stop the compulsive neutralizing reaction. The SUDS levels were continuously monitored. At the same time, the patient recorded imaginal exposures during the therapeutic session and listened to them between meetings as part of her own work. Behavioral techniques were used to support exposure with response prevention [33], such as exaggeration (multiplying the patient's fears verbally or in writing) and blocking (loudly saying "STOP" when a mental ritual occurs).

The in vivo exposures carried out included, among others: being in the company of other women, including those with a declared homosexual orientation (such as going to a lesbian bar), or spending time with Ms. Y without avoiding contact, including warm, friendly touch, such as a hug. There was a cognitive restructuring of dichotomous thoughts, such as that "a heterosexual woman will never like another woman" or that "if I spend time with other women willingly and often, it will prove that I am a lesbian." To achieve cognitive restructuring, psychoeducation based on a cognitive model and the use of paradoxical techniques, e.g., creating the worst-case, most difficult to bear scenario of the events that the patient feared were introduced [33]. Cognitive work was carried out in relation to automatic thoughts through discussion of thoughts, e.g., by analyzing arguments confirming the truth of a given thought and arguments denying its truth. In cases where the patient's

Chart 1. **Possible reasons for Mrs. X being hugged by Ms. Y**

Source: Own work

automatic thoughts related to feelings of responsibility, a cognitive technique was used that involved exploring alternative possible explanations for the identified circumstances. An example of this cognitive work is illustrated in Figure 1 and concerns the situation where Ms. Y hugged Mrs. X goodbye, which was associated with the automatic thought, “She thinks I’m a lesbian because of my behavior.” Together with the patient, a list of possible alternative reasons for Ms. Y’s behavior was prepared and the percentage of probability that each of them could have been the reason for her reaction was assessed.

Various interventions were used in the therapy process – both cognitive and behavioral. At the same time, it is worth paying attention to the rather long duration of therapy, which is the result of complex difficulties and numerous exposures made along the way of change – both cognitive (catastrophic interpretations, difficulty in tolerating uncertainty, beliefs that perpetuate the disorder) and behavioral (a complex set of neutralizing activities and rituals). Another challenge was the psychoeducation of the patient’s husband about the specificity of the symptoms, which was necessary due to her daily practice of exposure with response prevention of various nature – visual, situational and imaginal.

Conclusions

As a result of the cognitive-behavioral therapy based on exposure with response inhibition described in this study, the patient’s symptoms were reduced and the beliefs that were the source of the development of the disorder were restructured. The entire therapeutic process lasted 10 months and included 38 individual sessions lasting 50 minutes each and conducted once a week. At the end of the therapy, the patient reported episodic obsessive thoughts, the duration of which did not exceed a total of 30 minutes a day. Mrs. X stopped using neutralizing behaviors. The described process suggests the value and importance of exposure therapy with response inhibition in the treatment of patients with obsessive-compulsive disorder based on sexual orientation. It also seems valuable to use not only imaginal and in vivo exposures, but also visual exposures based on images, photos or films. Additionally, the presented work shows that it is sometimes necessary to modify classic therapeutic protocols or supplement them with elements that are important in the context of the patient’s difficulties (e.g., more detailed or longer psychoeducation of the husband). It is worth considering that in the diagnostic process itself it is extremely important to understand the mechanism of the disorder and to make a differential diagnosis, or to distinguish natural human fears and anxieties from symptoms that fit into the diagnostic classification criteria. At the same time, it must be remembered that the presented analysis concerns a single case, and the current state of research on the use of exposure with response prevention in a group of patients with SO-OCD is still insufficient and requires further in-depth analyses.

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Email address: sylwiimichalowskiej@gmail.com

Serdecznie zapraszamy na konferencję

„WZRASTANIE W RELACJI JA, TY, MY”

z okazji 25-lecia Katowickiego Instytutu Psychoterapii

Konferencja odbędzie się w dniach:

27–29 września 2024 roku w Katowicach

i będzie wyjątkowym wydarzeniem, gromadzącym wiele wybitnych osobistości z dziedziny psychiatrii i psychoterapii.

- **Prof. Bogdan de Barbaro,**
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- **Kathryn Rossi Ph.D.**

Konferencję poprzedza warsztat

„Życie wolne od strachu. Hipnoza terapeutyczna odkryta na nowo”

prowadzony przez Kathryn Rossi — światowej sławy psychoterapeutkę, nauczycielkę, autorkę i współautorkę wielu publikacji z dziedziny psychoterapii, hipnozy klinicznej i neurobiologii.

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