DOI: 10.7860/JCDR/2015/10773.5377

Case Report

Psychiatry/Mental Health Section

Homosexual Obsessive Compulsive Disorder (HOCD): A Rare Case Report

MANJEET S. BHATIA[1], JASWINDER KAUR[2]

ABSTRACT

HOCD is marked by excessive fear of becoming or being homosexual. The subjects often experience intrusive, unwanted mental images of homosexual behaviour. The excessive uncontrolled thoughts/doubts are very distressing and lead to compulsions in form of checking. We present a rare such case who was suffering from homosexual Obsessive Compulsive Disorder

Keywords: Compulsions, Checking, Homosexual, Obsessions

CASE REPORT

A 20-year-old male presented to the psychiatry OPD with complaint of being distressed about his behaviour of uncontrolled repetitive thoughts of being gay since four years. He was a drop out from Class 12th. He could not concentrate in his studies. He often had to repeat the same words while reading and hence could not learn in an efficient manner. Once he had read a line, he read it for 10 times before he proceeded to read the next line and this led to his academic failure. He often checked locks many times with the repeated doubt. He needed to count the money 3-4 times to make sure he did not count it wrongly and incurred any loss. He often counted numerals from 1 to 4 while opening and closing the door. This checking behaviour had increased for last six months. Subsequently, he developed sadness of mood, disturbed sleep and felt lethargic most of the day. He could not concentrate in his work. He felt hopeless and worthless. Unfortunately, he did not receive any treatment for the same. The patient did not suffer from any medical illness except for an episode of Dengue fever a year ago which resolved after taking symptomatic treatment for two weeks.

On taking detailed history, there were no significant perinatal events. Developmental history was apparently normal. But at the age of 16, patient had sexual contact on 2-3 occasions with one of his male friends living in the neighborhood. He had anal intercourse with him with his consent out of experimentation and denied any history of sexual abuse. Since then patient often had repeated thoughts of being gay although he never had any sexual encounter after that. He had constantly doubts about his sexual orientation. He was not able to control himself thinking about the same sex relationship. These thoughts were very distressing to him. He was worried that people of same sex might find him attractive and tried to avoid them. As an instance he ran away from the park when one of the elderly males tried to touch his face. The Y-BOCS (Yale- Brown Obsessive Compulsive Scale) scored 28 (indicating severe range). He did not have any other comorbid psychiatric disorder. His parents were illiterate and worked on daily wage basis. He had four siblings, none of the family member was suffering from any mental illness.

The entire laboratory parameters were within normal limits. The patient was started on Fluoxetine 20 mg daily, which was gradually increased to 40mg over a period of one month. He was psychoeducated and also started on Exposure and Response Prevention. He showed improvement over a period of 10 week in form of able to control his thoughts and checking behaviour and Y-BOCS score was 8 (indicating mild form). On follow up at 20 week, he was symptom free and working normally in a shop.

DISCUSSION

Obsessive compulsive disorder (OCD) is an extremely disabling anxiety disorder, with nearly two-thirds (65.3%) of the patients reporting severe impairment [1]. The common manifestations of OCD include contamination/washing, doubt/checking, ordering/arranging, unacceptable/taboo thoughts, and hoarding symptoms [2,3]. The sexual obsessions in OCD may include unwanted sexual thoughts about family or children, fears about engaging in sexually aggressive behaviour, or concerns about sexual orientation [4]. It is reported that homosexual obsessions have lifetime prevalence of about 11.9% among treatment-seeking people with OCD. In addition, it appears that more males experience sexual orientation obsessions than females [5].

In HOCD, Obsessions are characterized by the excessive fear of being or becoming homosexual and being ridiculed by others for being gay. There is experience of intrusive, unwanted mental images of homosexual behaviour. One fears that others may believe he/she is homosexual. Compulsions are usually in the form of checking.

While conceptualizing sexual obsessions, it is important to recognize that people with sexual obsessions find their thoughts immoral and do not wish to act them out. They are different from fantasies, as the obsessions are unpleasant and provoke guilt rather than being enjoyable [5,6]. The person in HOCD is not able to stop thinking about same-sex relationships, and the thoughts are severely distressing to him/her. Although in fantasy and dreams he fantasizes about the opposite sex. He often feels emotional intimacy with a partner of the opposite sex. He is worried that people of the same sex might be attracted to him. Sexual obsessions in OCD rarely produce sexual arousal [6,7]. These obsessions usually decrease sex drive. Obsessions about homosexuality differ from an individual who is actually gay because they do not feel attraction or arousal to members of the same sex. The obsessions result in guilt, shame, distress and anxiety [5-8]. The patient often tries to learn more about sexual identity issues to reassure himself that he is not a gay. The need of the hour is to understand the specifics of the patient's fears which will help to devise the appropriate psychotherapy [2,6,8].

Correct diagnosis, psychoeducation and open therapeutic communication provide the effective treatment. Cognitive behaviour approaches [5-8] produce clinically significant improvement but remission is the exception [8,9]. Cognitive behaviour therapy (CBT) includes psychoeducation, in vivo exposure, imaginal exposure, ritual/response prevention and mindfulness/acceptance approaches [5,6]. SSRIs (Selective Serotonin Reuptake Inhibitors) are useful in alleviating anxiety, depression and OCD [7]. CBT model explaining the role of thought suppression, checking, doubt and intrusive ideation

to patient and exposure and response prevention were found to be successful [8]. The present case showed complete improvement on Fluoxetine (a SSRI) and behavioural approach (Exposure and Response Prevention). The combination of these approaches have been reported in few case studies of HOCD [6,8].

REFERENCES

[1] Ruscio AM, Stein DJ, Chiu WT, et al. The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Mol Psychiatry.* 2010;15:53–63.

[2] Abramowitz JS, Franklin ME, Schwartz SA, et al. Symptom presentation and outcome of cognitive-behavioural therapy for obsessive-compulsive disorder. *J Consult Clini Psychol*. 2003;71:1049–57.

[3] Pinto A, Greenberg B, Grados M, et al. Further development of Y-BOCS dimensions in the OCD collaborative genetics study: symptoms vs. categories. *Psychiatry Res.* 2008; 160:83–93.

[4] Pinto A, Eisen JL, Mancebo MC, et al. Taboo thoughts and doubt/checking: A refinement of the factor structure for obsessive compulsive disorder symptoms. *Psychiatry Res*. 2007;151:255–58.

[5] Williams MT, Farris SG. Sexual orientation obsessions in obsessive-compulsive disorder: prevalence and correlates. *Psychiatry Res.* 2011;187(1-2):156–59.

[6] Williams M. Homosexuality anxiety: A misunderstood form of OCD. In: Leading-Edge Health Education Issues. Sebeki LV (ed). New York: Nova Science Publishers Inc., 2008:pp.195-205.

[7] www.brainphysics.com/sexual-obsessions.php.

[8] Gordon WM. Sexual obsessions and OCD. *Sex Relationship Ther.* 2002;17:343-54.

[9] Eisen JL, Godman MD, Keller MB. Pattern of remission and relapse in obsessive-compulsive disorder. *J Clin Psychiatry*. 1999;60:346-51.

PARTICULARS OF CONTRIBUTORS:

1. Department of Psychiatry, UCMS & GTB Hospital, Dilshad Garden, Delhi, India.
2. Department of Psychiatry, UCMS & GTB Hospital, Dilshad Garden, Delhi, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:

Dr. M.S. Bhatia,
Professor & Head, Department of Psychiatry, UCMS & GTB Hospital, Dilshad Garden, Delhi-110095, India.
E-mail : manbhatia1@rediffmail.com

FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Aug 04, 2014**
Date of Peer Review: **Oct 02, 2014**
Date of Acceptance: **Oct 06, 2014**
Date of Publishing: **Jan 01, 2015**