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

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Gender and sexual minorities are subjected to minority stress in the form of discrimination and violence that leads to vigilance; identity concealment and discomfort; and internalized homophobia, biphobia, and transphobia. These experiences are related to increased susceptibility to mental health concerns in this population. Historically, the behavioral treatment of sexual orientation (SO) and gender-themed obsessive-compulsive disorder (OCD) has inadvertently reinforced anti-lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+) stigma and contributed to minority stress in clients, treatment providers, and society at large. We present updated recommendations for treatment of SO- and gender-themed OCD through a more equitable, justice-based lens, primarily through eliminating exposures that contribute to minority stress and replacing them with psychoeducation about LGBTQ+ identities, and exposures to neutral and positive stimuli, uncertainty, and core fears. We also present recommendations for equitable research on SO- and gender-themed OCD.

Keywords: obsessive-compulsive disorder; LGBTQ+; SO-OCD; exposure and ritual prevention; treatment recommendations

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"I remember sitting with a client with sexual orientation-themed obsessive-compulsive disorder (SO-OCD) who was dry heaving watching a video of two men kissing as their exposure. During that season of my life, I was coming out to my family and I watched my client play out my fears that people did in-fact see me as undesirable, nauseating, and tolerable at best. In focusing on tolerance as the goal of SO-OCD exposures, I failed to educate, intervene, or narrate to myself how dehumanizing the work felt. It was not until stepping out of the role that I started to feel the aftershocks

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and regret about my work with SO-OCD clients. I passively assumed that my discomfort was the hard-earned process of habituation. Sitting in that tension led me to see that a justice-oriented lens was missing from the treatment process. SO-OCD exists in response to heteronormativity: the profound societal preference toward straightness. Although exposure and ritual prevention provided measurable improvement in symptom scores for my client, it did not address the root cause of why the client's SO-OCD was so distressing in the first place. Set apart from other diagnoses, SO-OCD is a behavioral health manifestation of homophobia that demands historical context, recognition of trauma, and individualized treatment planning to adequately treat the disease instead of its symptoms. In doing so, clinical progress does not have to come at a cost to LGBTQ+ people who are already on the fringes in society."

[OCD treatment provider]

Cultural competence is a continuous process that we acknowledge cannot be achieved fully, and as clinicians and researchers we must strive for cultural humility, a more active, lifelong process of reflection and self-critique (Hook et al., 2016). In the spirit of cultural humility, we acknowledge that society is continually progressing and that what was once deemed acceptable 20, 10, and even 5 years ago may no longer be acceptable or even be harmful. This paper, including the terminology used, is intended to capture a moment in time. We offer these reflections and recommendations without judgment on how sexual orientation obsessive-compulsive disorder (SO-OCD) has been historically treated by those within the field (including by us) and with great optimism for the future of our field. We begin by strongly encouraging the field to uniformly adopt the use of SO-OCD rather than homosexual OCD (H-OCD) to reflect current terminology related to sexual identity (Williams et al., 2014). This term (SO-OCD) also more accurately captures the range of potential obsessional content, including that one is bisexual or that a queer person may be straight (Goldberg, 1984; Williams & Ching, 2016). The term SO-OCD is increasing in popularity—however, the continued use of H-OCD in some professional circles warrants direct remarks on this topic. As such, we use the term SO-OCD throughout this paper.

The conversations that inspired this call-to-action paper began as a sharing of anecdotal concerns regarding the current practices used in treating SO-OCD that quickly grew into larger, more frequent, and often uncomfortable conversations with professionals across institutions. Our recommendations are framed within the concept of "justice," which we define as an equitable, thorough, and compassionate lens through which to conceptualize and implement mental health treatment so that all impacted persons—client, provider, and society—are respected. This call-to-action paper outlines the challenges faced by the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community, background and historical treatment of SO-OCD, updated justice-based clinical recommendations, and suggestions for continued research.

Statement of the Problem

Individuals who identify as LGBTQ+ comprise 4.5% of the U.S. population (Newport, 2018; UCLA Williams Institute School of Law, 2019).[1] Despite increased social acceptance and legal progress (Smith et al., 2014), LGBTQ+ individuals continue to experience minority stress that increases their susceptibility to mental health and socioeconomic disparities. Minority stress refers to experiences that are identity specific and that accumulate through the direct experience of external events, anticipation of external events, and internalization of negative attitudes and prejudices that are the catalyst for external events (Hendricks & Testa, 2012; Meyer, 1995; Rich et al., 2020).

Extant research has evidenced staggering financial, housing, health care, education/employment, and legal disparities for the LGBTQ+ community, particularly among transgender/nonbinary individuals and queer people of color (Casey et al., 2019; James et al., 2016; UCLA Williams Institute School of Law, 2019). Someone with intersecting marginalized identities (such as marginalized racial, ethnic, socioeconomic, or religious identities) is likely to encounter the multiplicative effects of exacerbated discrimination and violence. Holding multiple marginalized identities provokes dif-

[1] Definitions: LGBTQ+ is an acronym for the queer community and stands for lesbian, gay, bisexual, transgender, queer/questioning, and all others who identify within the community (National LGBT Health Education Center 2016). Sexual and gender identity are related but distinct constructs. Although over three quarters of gender minorities also identify as sexual minorities (Herman, 2016) and both groups experience minority stress (Meyer & Frost, 2013), it is important to note that these communities have their own unique experiences. Sexual minority refers to anyone who identifies as not heterosexual/straight, including those who are gay, lesbian, bisexual, pansexual, etc. Gender minority refers to anyone who is not cisgender (i.e., someone whose sex assigned at birth and gender identity are the same), including those who are trans, transgender man/masculine, transgender woman/feminine, nonbinary, nonconforming, genderqueer, agender, gender fluid/two-spirit, etc. Throughout this paper, we use these terms interchangeably.

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ferent forms of discrimination, and multiple forms of discrimination are related to more severe discrimination, trauma exposure, and mental health concerns compared to discrimination related to just one identity (Grollman, 2012; Reisner et al., 2016; Stuber et al., 2003). Of note, many mental health providers—especially those in rural communities—are unaware of and inexperienced in addressing the unique issues facing LGBTQ+ individuals, instead taking a colorblind-type approach to conceptualization and treatment rather than acknowledging the ways in which LGBTQ+ experiences differ from cisgender heterosexual experiences (e.g., Willging et al., 2006). Meanwhile, LGBTQ+ clients often report being discouraged from discussing gender and sexuality, secluded within residential/inpatient treatment settings, or denied services altogether. More than a quarter of surveyed transgender individuals report needing but not being able to obtain access to health care, 25% of whom needed but could not access counseling or psychotherapy; not surprisingly, not being able to obtain needed mental health care was associated with increased odds of having experienced discrimination (Bradford et al., 2013). Dissatisfaction with mental health treatment among transgender clients is associated with treatment providers' lack of competency and experience with trans clients, lack of sensitivity and responsiveness toward gender issues, inflexibility, and enacted stigma and discrimination toward trans clients (Duffy et al., 2016; Kattari et al., 2016; McCann, 2015; McCann & Sharek, 2016; White & Fontenot, 2019).

Because of these experiences, LGBTQ+ individuals often report maintaining vigilance in anticipation of these external stressors (Meyer, 1995), including in mental health spaces. To remain physically and psychologically safe, gender or sexual minorities may conceal their identity when in uncertain or ostensibly unsafe situations, increasing risk for internalizing mental health problems (Pachankis, Mahon, et al., 2020). They may begin to expect rejection from others due to the pervasive societal prejudices against LGBTQ+ individuals, leading to avoidance of situations in which rejection may be more common, such as public restrooms, gyms, clothing shops, public transportation, or health care settings (Ellis et al., 2014; Rood et al., 2016).[2] Expectations of rejection are even more prevalent among trans communities of color in which rejection is expected both due to one's gender and racial or ethnic identity. Unsurprisingly, LGBTQ+ individuals often internalize these societal negative attitudes and prejudices (Meyer, 1995; Puckett & Levitt, 2015). This internalized sense of stigma has been described as potentially most damaging because it can negatively impact one's ability to cope with and remain resilient against external stressors.

Taken together, these minority stress processes of external stressors, anticipation of external stressors, and internalized stigma appear to explain the significant disparities in mental health concerns. This population, compared to their cisgender and heterosexual peers, experiences a greater incidence of several psychological disorders, including eating, mood, anxiety, attention, substance use, psychotic, posttraumatic stress, and obsessive-compulsive disorders, as well as self-injury and suicidality (Carmel & Erickson-Schroth, 2016; Cochran et al., 2003; Gilman et al., 2001; Millet et al., 2017; Oswalt & Lederer, 2017; Roberts et al., 2010; Rowe et al., 2015; Shipherd et al., 2011). Research consistently shows that virtually all LGBTQ+ individuals report experiencing at least one traumatic event in their lifetime (e.g., James et al., 2016; Pinciotti & Orcutt, 2020; Shipherd et al., 2011).

Given the apparent link between trauma exposure and OCD (e.g., Fontenelle et al., 2012; Pinciotti, Riemann, et al., 2021), it is no surprise that gender and sexual minorities also evidence higher rates of OCD than the general population. Gender minorities are six times more likely to be diagnosed with or treated for OCD (8.0%) in the last 12 months compared to cisgender women (2.2%) and men (1.3%; Oswalt & Lederer, 2017). Similarly, sexual minorities are nine times more likely to be diagnosed with or treated for OCD (9.0%) in the last 12 months compared to their heterosexual peers (1.0%; Pelts & Albright, 2015).

Gender and sexuality themes are sometimes implicated in the presentation and treatment of OCD. Historically, these presentations are treated the same as other OCD presentations (e.g., contamination, scrupulosity) without consideration for the impact on the client, provider, and society at large. Historically utilized treatment strategies often capitalize on stereotypes and fears associated with LGBTQ+ people, prioritizing OCD symptom reduction in the individual over damage incurred to the LGBTQ+ community. The implications of these presentations for the LGBTQ+ community warrants reflection and updating of professional expectations and treatment recommendations.

[2] Among transgender individuals, these situations evoke expectations of rejection because they represent situations defined by a clear gender binary system and/or include gender markers, they involve the potential of meeting new people, and/or carry a risk of not "passing" as cisgender (Rood et al., 2016).

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BACKGROUND ON SO- AND GENDER-THEMED OCD

SO-OCD is endorsed by 10.0–12.0% of individuals with lifetime OCD, including 8.0% who report currently experiencing obsessions related to SO (Pinto et al., 2008; Williams & Farris, 2011). It is likely that rates of diagnosed SO-OCD are underestimated; several studies have found that OCD symptoms related to SO are most likely to be misdiagnosed (77.0–84.6%), a glaring finding given that the rates of OCD misdiagnosis are already quite high (38.9–50.5%; Glazier et al., 2013, 2015). Interestingly, although men are twice as likely to experience SO-OCD, women report higher levels of distress related to SO-OCD (Williams & Farris, 2011; Williams et al., 2015).

Obsessions typically center on doubts about one's SO, fear of becoming gay/lesbian/bisexual, and/or fears that others will perceive one as gay/lesbian/bisexual (Williams, 2008). Such obsessions, as with other presentations of OCD, are egodystonic and typically do not align with the individual's actual beliefs or feelings toward LGBTQ+ people. The onset of SO-OCD symptoms can coincide with an experience involving misinterpreting a bodily reaction (e.g., shifts in pressure around the genitals, erection or vaginal lubrication, or the absence of sexual arousal during syntonic sexual experiences), or during a period of sexual development, such as adolescence, when one has less experience and knowledge about sexual identity, may be subjected to anti-LGBTQ+ stigma at school, and is simultaneously experiencing more physiological reactions (Williams & Wetterneck, 2019). Related compulsions may include body scanning and checking for signs of arousal, self-assurance or reassurance seeking from others (including online forums) about one's SO, mentally reviewing interactions with members of the same gender or other past experiences, avoidance of LGBTQ+ triggers (e.g., television shows, neighborhoods, maintaining physical distance from members of the same gender), testing and comparing their physiological arousal to heterosexual and LGBTQ+ pornographic content, and/or engaging in increased sexual activity.

Of note, we could find no empirical study of gender-related OCD, or obsessions centered on one's gender identity (e.g., doubt about gender identity, fear that one will become transgender, and/or fear that others will perceive one as transgender), despite conceptual overlap with SO-OCD. One published case study details the treatment of an adult cisgender gay man who developed doubt and anxiety about his gender identity (Safer et al., 2016). He reported having a "panic-type reaction" to the thought that he was transgender, believed that he must immediately explore gender-affirming surgery options, and engaged in compulsions to try to obtain certainty about his gender identity (e.g., "testing" his reactions to transgender-related thoughts, seeking reassurance from others about whether he could "get rid" of his obsessions). An adult cisgender heterosexual individual with a related clinical presentation was treated by one of the authors after he developed obsessional doubts related to both his sexual and gender identity. Believing he could not proceed with living an authentic life until he "figured" out these questions, he engaged in compulsions mimicking harmful gay and transgender stereotypes (e.g., dressing, speaking, and gesturing effeminately) to test whether he felt an aversion to his new "lifestyle," sought reassurance from peers in the LGBTQ+ community, and researched online forums. In our clinical observations, gender-related OCD is currently less prevalent in clinical settings than SO-OCD, yet with the number of individuals openly identifying as transgender continuing to increase (Meerwijk & Sevelius, 2017; Williams & Ching, 2016), gender-related OCD may become more prevalent as the general public has greater exposure to an identity onto which OCD could latch.

With the basis that we all ascribe to some level of implicit homophobia, biphobia, and transphobia[3]—whether consciously or otherwise—we note that many individuals with SO- and gender-related OCD are not overtly heterosexist or transphobic. Many individuals with SO-OCD feel positively about the LGBTQ+ community and reject anti-LGBTQ+ sentiments. Instead, SO-OCD often stems from a fear that the individual will have to categorically change their life, that they will no longer have access to the gender to which they are attracted, and that they will have to give up a satisfying sexual life in favor of something that feels foreign or unappealing (Williams, 2008). Indeed, research examining the underlying fear driving the obsessions has provided further evidence that for many individuals, the core fear is largely about the uncertainty/doubt of one's iden-

[3] Being socialized within a society that is systemically homophobic, biphobic, and transphobic, and reinforces heterosexism and cissexism signifies that no one is immune to the internalization of these prejudices as implicit biases (see McDowell & Berrahou, 2018, for a review). While certainly many can (and do) work to recognize and correct aspects of homophobia, biphobia, and transphobia that have been personally internalized, these biases can never be fully eradicated until the source itself (i.e., society) is fundamentally changed.

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tity and feeling as though one must determine their sexual identity to live a fulfilled, authentic life (Williams et al., 2015). The second most endorsed underlying fear is concern about the judgment of others if they were indeed gay/lesbian/bisexual (e.g., "I worry that others will think negatively about me because of my [SO-related] thoughts"). This may be particularly relevant to people who experience obsessions related to scrupulosity and struggle with obsessions that being someone who is LGBTQ+ is equivalent to "committing sin" or "behaving immorally." In these situations, people who experience SO-OCD obsessions may also be surrounded by societal, religious, and familial pressures and messages around disclosing the content of their obsessions (e.g., Siev et al., 2011; Witzig & Pollard, 2013). This would make it even more difficult to disclose SO-OCD symptoms and likely increase internalized stigma toward the self as someone with SO-OCD and stigma toward the LGBTQ+ community. There are some individuals with SO-OCD whose fears are driven by their own immorality beliefs (e.g., "People who have gay sexual thoughts are immoral"), so it is important to note that while individuals with SO-OCD are not necessarily more homophobic or biphobic than the general population, there are some who are.

Clinical Recommendations

Exposure and ritual prevention (ERP) is considered the gold-standard behavioral treatment for OCD (see Hezel & Simpson, 2019, for a review). Broadly, the treatment involves learning to approach rather than avoid feared stimuli, while intentionally resisting rituals/compulsions and other safety behaviors. Like other OCD presentations, SO- and gender-themed OCD have historically been treated similarly: by identifying the feared or avoided scenarios and the catastrophic beliefs associated with them and generating exposure ideas to target them.

Although symptom presentation informs treatment planning (e.g., identifying feared/avoided situations for exposures and associated rituals to prevent), ultimately the underlying core fear (if present) should be identified, tolerated, and challenged (Gillihan et al., 2012). For example, an individual with harming obsessions may complete exposures involving holding a knife near loved ones, but their hierarchy should also include exposures to their core fear of being a dangerous person. Some clinicians might downplay the relevancy of the surface-level symptoms, believing instead that every OCD presentation is effectively the same. Although we agree in principle, we argue that SO- and gender-themed OCD represents a unique presentation because it presents (and is treated) in a way that can further marginalize an already marginalized community. Other OCD presentations, such as contamination, do not typically implicate a marginalized group and therefore exposure to contamination themes reflective of the client's obsessional content is intuitive and ostensibly harmless. It makes sense to conduct exposures to both the surface level, as well as the core fear. In SO- and gender-themed OCD, however, extra caution is required to ensure that a population that already experiences prejudice and discrimination is not being further harmed through the reinforcement of stereotypes and anti-LGBTQ+ stigma. In the above knife exposure example, it is important to note that such an exposure would not be conducted with a family member, provider, or community member who has a related history of trauma. It is not acceptable (or necessary) to brandish a knife in a threatening manner purely for exposure purposes in the same way that it is not acceptable (or necessary) to discriminate based on sexual or gender identity under the guise of ERP.

Consider that while obsessions and compulsions can latch on to any theme, the theme is virtually always objectively negative or disturbing. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) defines obsessions as involving content that would cause marked anxiety or distress in most individuals. Although we acknowledge with humility that anything in OCD is possible, the likelihood that someone would develop obsessions around becoming rich, wildly attractive, and adored is extremely low. Instead, obsessions are likely to latch on to concepts deemed by society or the individual as "undesirable"—germs, harm, sacrilege—or threaten the very values that the individual holds dear (e.g., being a good parent to a newborn). We argue that SO- and gender-themed OCD, therefore, exists as a reflection of societal anti-LGBTQ+ stigma and that without the underlying stigma, this presentation of OCD would be highly uncommon. This is further evidenced by findings that many individuals with SO-OCD do not endorse hating or being disgusted by the LGBTQ+ community, yet realize that being gay/lesbian/bisexual could have a negative impact on their existence within a homophobic, biphobic society.

Although the purpose of this paper specifically focuses on considerations to reduce harm toward LGBTQ+ populations for clinicians using ERP to treat SO- and gender-themed OCD, we also rec-

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ommend that clinicians consider growing their own cultural humility in their awareness of relevant issues for LGBTQ+ people. Boroughs et al. (2015) outline guidelines to promote culturally competent care for LGBTQ+ people. Although this paper is specific to psychologists, it can apply to all mental health professionals. Boroughs and colleagues define cultural competence with LGBTQ+ populations as understanding and awareness of one's own beliefs, biases, and attitudes toward LGBTQ+ people, knowledge and understanding of LGBTQ+ populations, and skills and tools to provide culturally sensitive care to LGBTQ+ populations with the goal of reducing stigma and harm toward LGBTQ+ people.

To reduce harm to the LGBTQ+ community, we recommend three target areas when treating clients with SO- and gender-themed OCD: (a) psychoeducation about LGBTQ+ identities, (b) engagement in neutral or positive exposures, and (c) engagement in exposures to uncertainty and core fears.

PSYCHOEDUCATION

Psychoeducation about LGBTQ+ identities serves two simultaneous functions: to provide corrective information where needed (particularly in situations in which the client ascribes to homophobic, biphobic, or transphobic beliefs), and to provide opportunities for exposure to anxiety-provoking content that is both accurate and justice oriented. Some examples of psychoeducation might include the development and fluidity of gender and sexual identity, differences between aspects of gender and sexual identity (e.g., gender identity vs. gender expression vs. sex assigned at birth; romantic vs. sexual attraction), prevalence rates for gender and sexual minorities (including how these are increasing over time in younger birth cohorts; Newport, 2018), the lack of biological differences between LGBTQ+ and heterosexual cisgender individuals, the historical context for LGBTQ+ culture (e.g., Stonewall riots), minority stress and its consequences, and pride and resilience in the LGBTQ+ community. If it can occur without providing reassurance, clinicians may also process aspects of these themes that are specific to the client's experience (e.g., describing components of both femininity and masculinity present in the client's identity and expression). For some individuals, personalizing the content may be both enlightening and anxiety provoking.

Psychoeducation may not be relevant for all clients, including those who are LGBTQ+ and/or very knowledgeable about LGBTQ+ identities. Among LGBTQ+ patients, clinicians may consider utilizing aspects of Pachankis et al. (2019) and Pachankis, McConocha, et al. (2020) transdiagnostic minority stress interventions for sexual minorities. Being LGBTQ+ does not automatically exclude these individuals from benefiting from psychoeducation, as some LGBTQ+ individuals with SO- or gender-themed OCD may have internalized stigma that is compounded by their upbringing (e.g., religious) or OCD-related distortions. Clinicians should use judgment when determining who may benefit from LGBTQ+ psychoeducation and what the function of its use is for each individual client.

In addition to psychoeducation for the client, clinicians should also be educated and informed on LGBTQ+ identities and relevant issues for this population. Boroughs et al. (2015) encouraged clinicians to be aware of and equipped to address historical context for LGBTQ+ people, stay informed of sociocultural changes (positive or negative), and the impact that context and changes have on LGBTQ+ people. In order to accurately provide psychoeducation to clients, clinicians themselves must be aware of history and issues relevant for LGBTQ+ people.

NEUTRAL AND POSITIVE EXPOSURES

Neutral exposures include those that directly target aspects of being LGBTQ+ but do so in a way that does not propagate harmful stereotypes and misinformation, normalize disgust, hateful, or sexualizing reactions to LGBTQ+ people, put LGBTQ + people at risk, nor tokenize and/or use LGBTQ+ individuals as props. Such exposures might involve neutral LGBTQ+-related stimuli, such as pride flags, neutral media (e.g., films or books that neutrally feature LGBTQ+ individuals without emphasizing trauma and minority stress), write a "coming-out" letter to a loved one, or talk to an individual of the same gender and tolerate the uncertainty that the individual may believe the client is attracted to them. If appropriate, clinicians might also consider using positive exposures, or those that promote positive attitudes about the LGBTQ+ community without providing reassurance related to one's OCD (see Table 1 for additional hierarchy recommendations). In addition to preparing these exposures for clients, clinicians should also consider their own beliefs, biases, and attitudes toward LGBTQ+ populations to assess whether the exposures they are creating either perpetuate or eradicate harmful beliefs about the LGBTQ+ community (Boroughs et al., 2015).

As with all OCD treatment, generating hierarchy exposures should be nuanced and specific to the individual client's needs. For example, if

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Table 1
Recommendations for Creating a More Justice-Oriented Exposure Hierarchy

Traditional hierarchy	Points for reflection	Justice-oriented hierarchy
Provider says, "You seem gay."	Perpetuates culture of outing queer people with disproportionate power dynamics.	Client states, "I am questioning my sexual orientation." Provider provides neutral response.
Write worry script about suddenly becoming gay/bi/trans.	Reinforces misinformation that LGBTQ+ people spontaneously choose their sexual orientation/gender identity.	Read/write a coming-out letter.Tolerate uncertainty about consequences of being gay/bi/trans (e.g., loss of relationships, being labeled a "liar") .
Shake hands with gay person and resist washing hands.	Tokenizes queer people with the potential of "outing" them and reinforcing stigma that they are broken, undesirable, and disgusting.	Hold pride flag.
Sit next to LGBTQ+ person.		Sit next to individual who may or may not be LGBTQ+ and tolerate uncertainty of not knowing.
Talk to someone who "looks" queer.	Reinforces belief that sexual and gender identity can be determined through appearance alone.	Attend and participate in an LGBTQ+ event where allies are welcome.
Client states, "I might be gay or bi." Provider gives critical response.	Creates an unsafe environment for community-based treatment for LGBTQ+ individuals.	Client writes, "I'm gay" on a piece of paper and hands to provider. Provider gives neutral or positive response (if doing so does not provide reassurance).
Client publicly dresses in overly feminine or masculine attire to mimic how it may feel to be gay/lesbian/bisexual/trans.	Reinforces stereotypes for client and others about gender expression in LGBTQ+ people; potentially puts client in dangerous public situations.	Wear a rainbow bracelet.
Shop in gendered section of clothing stores.		Read about the difference between gender/sexual identity and gender expression.
Someone states, "You look gay/ lesbian/bisexual/transgender."		
IF EVOKES DISGUST:		
Look at photo or watch video of two queer people kissing.	Normalizes disgust as an expected reaction to LGBTQ+ people, reinforces the belief that same-gender relationships are "undesirable."	Watch LGBTQ+-themed movies made by LGBTQ+ writer/directors.
Imaginal exposure involving client having same-gender sexual interaction.		Write a worry script about the consequences of revealing to romantic partner that they are not attracted to them/their gender.
		Write an imaginal exposure about coming out and having a wonderful same-gender relationship and supportive sexual and gender minority friends.
Write or say a homophobic/ biphobic/transphobic slur.	Normalizes use of harmful slurs and potentially adds minority stress to providers/others.	Client describes to provider the harmful impact of anti-LGBTQ+ slurs.
For assigned male: Talk to stranger in a "gay" way (e.g., effeminate voice, using "totally" and "like," flamboyant hand gestures). For assigned female: Talk to stranger in a "butch" way (e.g., lower voice, using "dude" and "bro," masculine body posture [e.g., sitting with widely spread legs]) .	Reinforces stereotypes about gay men and lesbian women, conflates sexual orientation with gender expression, erases the potential combinations of orientation and expression.	Talk to stranger and tolerate uncertainty that they may think you are attracted to them. Compliment someone of the same gender.

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Describe homosexual acts (e.g., oral sex) to member of the same gender.	Perpetuates hypersexualization of LGBTQ+ community.	Read and then educate another person about the harmful sexualization of the LGBTQ+ community. Participate in LGBTQ+ social justice activities.

Table 2
Questions to Consider When Designing Gender-Themed and SO-OCD Exposures

What is the client learning from this exposure?
What is the function of the exposure?
What is this client's sexual orientation/gender identity?
Does this exposure tokenize LGBTQ+ people?
Do LGBTQ+ people have agency in participating in the exposure?
Does this exposure make queer people a prop?
Does this exposure play off stereotypes/stigma/prejudice?
Does this exposure exploit queer people?
Does this exposure ignore historical trauma for LGBTQ+ people?
Can a downward-arrow approach be used to create a more targeted exposure?
Can you make this exposure a different way and get the same result?
Can the exposure be made about appreciation/celebration over tolerance of a community?
Would this exposure need to be clarified to peers in a group-based treatment setting?
Would this exposure "out" an individual?
Is the client's anxiety/distress rooted in homophobia/biphobia/transphobia?
Is the exposure addressing the client's OCD or anxiety about their own sexual orientation?
Is it appropriate for the client to have anxiety about this behavior/idea?
Would you feel comfortable doing this exposure in front of a queer person?

watching a video of two gay men kissing evokes disgust in the client, its inclusion on the hierarchy would reinforce the notion that gay people are disgusting and that gay relationships are undesirable, and the exposure should thereby not be included. If, however, the client is concerned that they will be judged by others for watching the video, inclusion on the hierarchy may be acceptable pending the content is appropriate and does not propagate stereotypes (e.g., a well-done romantic scene would be preferred over a raunchy, hypersexualized scene). In many cases, clinicians believe that clients could benefit from increased contact with LGBTQ+ individuals—to challenge both anxiety and biases—however, these exposures should be nuanced and thoughtfully assigned. For example, it would not be recommended to have clients interact with individuals who they perceive to be LGBTQ+ based on stereotypes about what LGBTQ+ people "look like"—instead, clients should be encouraged to interact with all types of people and tolerate the uncertainty that some may be LGBTQ+. Conducting an exposure the latter way ensures that harmful stereotypes are not being reinforced while also providing a more potent exposure stimulus because it accurately highlights the uncertainty that sexual or gender identity cannot be determined through appearance alone and that virtually anyone with whom clients interact can be LGBTQ+.

CORE FEAR EXPOSURES

Core fear exposures require use of the downward-arrow technique to better understand the true fear underlying the surface-level presentation. Focusing solely on the surface-level presentation and not the core fear runs the risk of not truly getting at the underlying fear that the individual has and may increase the likelihood of relapse. A sample script on how a clinician can utilize the downward-arrow technique with gender-themed OCD follows.

PROVIDER (P): For the past year you have worried that you might be transgender. Why do you think that is?

CLIENT (C): I really don't know. I have a friend who is transgender and I support them. The thought just came to me one day, and I haven't been able to shake it since.

P: You mentioned that you feel very positively toward the trans community. If you somehow were able to figure out with certainty that you

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were, in fact, transgender, what would be so bad about that?

C: I guess it would just be different from how I've lived my life so far. I keep having this image of coming out to my friends and family that feels really distressing.

P: That's true, it would certainly require you to think about yourself and your identity differently than you had been, and perhaps you might decide to make changes in your life to be more congruent with your gender identity. What about this image of coming out feels so distressing?

C: Having to tell them that the person they thought they knew no longer exists...

P: Your new identity would feel like it conflicted with your old identity, which for most people might take some getting used to. I'm curious, though, what about this discrepancy feels so much more distressing to you?

C: Because it would mean that I had been living a lie.

P: So, you feel like coming out as trans would mean that you had been lying to everyone—and perhaps yourself—about who you truly are, and that everything about your life to that point would be somehow tainted by this "lie"?

C: Yes, exactly! It makes me feel like a liar and a fraud.

In this example of the downward-arrow technique, the provider was able to determine that this client's gender-themed OCD was not driven by transphobic beliefs and that the core fear was not simply that the client was transgender but instead was able to determine what it meant to the client that they might be transgender—in this case, that the client was secretly lying to everyone about their identity. With this knowledge, the provider now knows that they likely do not have to provide extensive psychoeducation about the trans community to combat inaccurate transphobic beliefs because the client has indicated positive experiences with and support of the trans community, and the provider can focus exposures on the theme of being a liar or misleading others. These exposures can certainly center on the theme of being misleading about their gender identity (e.g., write a coming-out narrative about being trans), but can also involve the theme of lying more broadly (e.g., share stories with provider about times in which they were untruthful with others).

Given that many individuals with SO- or gender-themed OCD indicate a fear of simply never knowing who they are and how they identify, relevant core fear exposures may involve tolerating uncertainty to experiencing major life events (or the lack thereof) without knowing with certainty who they are. Exploration of one's gender identity or SO, as described under the "Psychoeducation" section, may be another opportunity for core fear exposures, particularly if the client is able to lean into the fluidity and arbitrariness of identity labels without obtaining reassurance. Imaginal exposures should also center on core fears rather than relying on stereotyped fears about being LGBTQ+. We have provided a traditional (problematic) imaginal exposure and a justice-oriented (affirming) imaginal exposure for comparison in the Appendix (adapted from Williams & Wetterneck, 2019).

When generating exposure ideas, clinicians should reflect on the questions in Table 2 to ensure that they are constructing a justice-oriented exposure hierarchy that considers the impact of the treatment on both the individual with OCD and others.

Additional Considerations

OCD AND ANXIETY IN SEXUAL AND GENDER MINORITIES

Additional considerations should be made by clinicians when working with individuals with OCD and other anxiety-based disorders, as OCD and anxiety disorders are particularly common among gender and sexual minorities (Oswalt & Lederer, 2017; Pelts & Albright, 2015). These rates suggest that clinicians treating OCD should expect to work with LGBTQ+ clients, including those who present with OCD with gender and sexuality themes, and should thus remain updated on current best practices (see Boroughs et al., 2015, for guidelines on LGBT cultural competence for psychologists). Ongoing efforts to remain culturally competent and humble are particularly important given emerging findings that gender minorities may not benefit from evidence-based treatment to the same extent as cisgender clients, including intensive OCD treatment (Hollinsaid et al., 2020; Pinciotti, Nuñez, et al. 2021). In particular, gender minorities with OCD experienced significant improvement only in some symptom dimensions and required an additional 10.5 days of intensive treatment to obtain the same reduction in overall OCD severity from admission to discharge (Pinciotti, Nuñez, et al. 2021). Clients receiving intensive treatment for obsessive-compulsive and related disorders were also found to improve less over the course of treatment, have a lower quality of life, and greater symptom severity when they held more marginalized identities (e.g., gender or

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sexual minority, racial minority; Wadsworth et al., 2020). These findings likely reflect the mental health damage incurred by minority stress experiences—both prior to admitting to treatment programs, as well as during their stay.

DIFFERENTIATING SO RUMINATION

Exploration and development of sexual identity is a normative developmental process. Among adolescents, who are developing multiple aspects of their identity, exploring one's sexual identity is normal and expected regardless of the adolescent's particular SO (Savin-Williams, 2011). Further, it is not uncommon for sexual minorities to ruminate about their sexual identity, especially among individuals who struggle with being uncertain about their sexual identity (Borders et al., 2014). SO rumination can present similarly as SO-OCD obsessions in that they may be obsessional or compulsive in nature and can evoke depressive and anxious symptoms. However, SO rumination develops as a reaction to internalized stigma and may be conceptualized as a coping mechanism in response to minority stress (Galupo & Bauerband, 2016), whereas SO-OCD obsessions develop from overinterpreting unwanted sexual thoughts. SO rumination presents as egosyntonic in that sexual identity, attractions, and behaviors are typically consistent, whereas SO-OCD obsessions are egodystonic in that these historical patterns are inconsistent from each other (e.g., the individual is sexually attracted to and enjoys sexual intimacy with their same-gender partner but obsesses over the possibility that they instead prefer other-gender partners). Williams (2008) and Luxon et al. (2021) provide thorough recommendations for differential diagnosis of normative SO rumination in sexual minorities from SO-OCD.

MINORITY STRESS EXPOSURES

Although treatment providers cannot erase the minority stress experiences that each LGBTQ+ client brings to treatment, they can make efforts to understand their impact and, importantly, to not contribute to minority stress. For this reason, providers should consider against using minority stress as a target for exposures and should absolutely not do so if the client themself has not explicitly requested them. The propensity to commit microaggressions is strongly predicted by aggression and hostility, so committing these actions is inherently an act of aggression regardless of intention (Williams, 2021). In addition to contributing to minority stress, conflating identity-based distress with OCD and anxiety can put the client in disproportionate power dynamics with the clinician, damage therapeutic trust and alliance, invalidate the client's lived experience, and communicate that it is their responsibility to mitigate the occurrence and impact of minority stress, rather than the responsibility of others to educate themselves and be held accountable for their actions.

For example, a clinician who notices that their transgender client feels anxious, distressed, and dysphoric when they are misgendered or "deadnamed" (e.g., using an individual's given instead of chosen name), and struggles to assertively correct the transgressor, may view this as an opportunity for the client to challenge social anxiety and avoidance with assertiveness skills. The well-intentioned clinician may wrongly conceptualize this anxiety and reduced social assertiveness through the same lens as social anxiety experienced by cisgender individuals and may assign an exposure for the client to be intentionally misgendered/deadnamed by an authority figure in public (e.g., during group therapy) and have the client practice asserting themselves with the authority figure. In this exposure, the clinician has put the client in a situation where they are being intentionally subjected to a microaggression and, by doing so, is perpetuating the belief that it is the responsibility of transgender people to empathize with and educate cisgender people on microaggressions, and that declining to effectively address ignorance in the moment reflects a failure on the transgender individual's part to respond assertively.

In reality, there are many reasons why a transgender person may feel uncomfortable or unsafe asserting their gender identity with people in positions of authority, loved ones, or strangers, including but not limited to the very real threat of physical or sexual violence. Recognizing the unique identity-specific social anxiety frequently reported by transgender people, Ho and Mussap (2020) created a measure of social anxiety that is specific to trans and gender-diverse individuals. Although the reported experiences of identity-specific social anxiety overlaps somewhat with generic symptoms of social anxiety, the study highlighted that many trans and gender-diverse individuals experience social anxiety specifically related to anti-trans stigma in society that can unfortunately, in many ways, serve an adaptive function until anti-trans stigma is eradicated. This exposure example also presupposes that transgender people owe others an explanation of their gender, forcing them to out themselves in situations where the potential consequences of being identifi-

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ably trans may not outweigh the risks, and communicates the message that the minority group is always responsible for educating and conforming to the majority group. When done in a group setting, as in the above example, such an exposure can also be triggering for other treatment peers and providers. Neglecting to acknowledge these factors denies the lived reality of transgender individuals and perpetuates a cis-normative culture in which deviation from cisgender is perceived as "other."

For these reasons, we strongly recommend against exposures targeting identity-based anxiety or OCD unless explicitly requested by the client themselves and is done so in a sensitive and collaborative manner (e.g., using "situational" exposures instead of planned ones or practicing correcting the clinician during individual sessions rather than in front of others). In such cases, the clinician should seek to understand the client's lived experience, but not rely solely on the client to educate them on the impact of microaggressions. The clinician should also maintain an open line of communication with the client, frequently checking in with them about the burden of minority stress that they may be incurring during such exposure work and adjusting as needed. Conversely, strong, negative, and often avoided emotions associated with past minority stress experiences (e.g., shame, fear) may be targeted by having the client expose themselves to a particularly emotional minority-stress memory from their past (Burton et al., 2019). Avoidance of emotions associated with minority stress, while potentially adaptive in the moment, reinforces and strengthens minority stress-driven emotions and may lead to other problematic avoidance or coping behaviors. Exposure to a past minority stress experience teaches the client to approach their painful emotions, normalize their emotional reactions, and ultimately habituate to them, without artificially adding to the minority stress they have already experienced.

Alternatives to targeting these microaggressive experiences outside of exposure work include building assertiveness and communication skills (when needed/requested), self-compassion for internalized shame, and discussion and validation of situations in which asserting oneself may not be safe or worthwhile. To the extent that a client's core OCD fear intersects with an aspect of their gender or sexual identity (e.g., "I am contaminated and disgusting because I am transgender"), the clinician should disentangle these intersections and consider using other techniques to process and challenge identity-based shame, such as through self-compassion.

QUEER PEOPLE AS PROPS

Clinicians should also avoid using queer people as props. For example, while it may seem useful to have a client with SO-OCD sit next to a lesbian staff member in the clinic, this type of exposure tokenizes the staff member, potentially outs them to others without their affirmative consent,[4] and reinforces the stigma that they are disgusting and undesirable. Further, depending on the presentation of OCD, it may reinforce the notion that their SO is "contagious" (the latter of which is a parallel to the homophobic belief that people are more likely to "turn" lesbian or gay if they are exposed to queer content). The clinician should also consider the minority stress that they may be unnecessarily adding onto the staff member by using one aspect of their identity as a prop for treatment. Similar to the above comments, intentional and considerate dialogue can be had between clinician and client if this is an exposure the client has explicitly requested (e.g., because they want to be able to interact with LGBTQ+ people without rituals), and affirmative consent must be obtained by the individual being involved in the exposure.

RELIGIOUS INTERSECTIONS

In some cases, SO- and/or gender-themed OCD intersects with religious-based scrupulosity concerns. In such cases, individuals may go to extreme lengths to avoid being associated with LGBTQ+ people, such as avoiding going to religious services or other places where LGBTQ+ people might be, feeling the need to warn LGBTQ+ people that they will go to hell if they behaviorally express their gender or sexuality, or avoiding LGBTQ+ people out of fear that their gender or sexuality will be contagious. Often, these behaviors are rooted in a fear that one will go to hell or be excluded from their religious community for being and/or supporting LGBTQ+ people. However, for some, disgust underlies negative religious-based views of LGBTQ+ people (Olatunji, 2008).

First and foremost, it is not the clinician's role to take a judgmental stance toward the client's religious views but rather attempt to move them away from all-or-nothing thinking regarding others who may practice life differently, and instead cultivate an open mind about the possibility of having positive interactions and relationships with LGBTQ+ individuals. Consultation by the clinician with a religious leader from the cli-

[4] We use the phrase "affirmative consent" here to highlight that power dynamics may make a person feel uncomfortable declining such an offer, so this consent should be clear and enthusiastic rather than coercive.

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ent's faith will provide a more accurate understanding of the community's attitudes toward LGBTQ+ individuals, including whether the client's views are considered extreme. If the client belongs to a strict faith with oppositional attitudes toward LGBTQ+ individuals, the client is encouraged to consider their own freedom of choice to determine which aspects of their faith are most consistent with their values. In either case, the client should consider that their scrupulous beliefs are rooted in fear and anxiety rather than in healthy faith-based values of peace, serenity, and connection, and that they can strive to respect and accept—without necessarily approving of—others who practice life differently. A discussion of core values and how these might influence their respectful interactions with LGBTQ+ individuals may help guide treatment goals and exercises.[5]

PERSONAL CONSIDERATIONS FOR CLINICIANS

Although the focus of this paper is on treating people with SO-OCD, it is also important to recognize that encountering patients who may be verbalizing homophobic, biphobic, and transphobic beliefs may be harmful and negatively impact clinicians, especially for those who identify as part of the LGBTQ+ community. Individual experiences may vary, so it is important for clinicians to consider how these situations may affect them and their own response either in the moment or afterward. Wheeler et al. (2019) offer suggestions for how to respond to microaggressions and overt discrimination, including repeating the client's statement to allow time for reflection, sharing one's own response to communicate impact, and debriefing with others outside of the treatment room. Williams (2020b) also provides suggestions on how to respond to microaggressions committed by clients, including taking time to understand the client's perspective, considering how to best proceed to handle the misinformation, and opening a difficult dialogue around it. It may also be helpful for clinicians to consider community spaces where they may feel safe and validated while debriefing these experiences and discussing individual, organizational, and systemic options for how to respond.

[5] To focus the scope of the current paper, we chose to discuss these recommendations within the context of SO- and gender-themed OCD. We acknowledge, however, that a smaller proportion of individuals with OCD present with racism-themed fears (Williams, 2020a). Obsessions can include fears that one is racist or will be perceived as racist, or that one will engage in a sudden racist behavior (e.g., blurting a racial slur). Like SO- and gender-themed OCD, this OCD symptom presentation implicates a marginalized population and thus, study and treatment of racism OCD should be done through a critical lens. Fortunately, we believe that many of our recommendations regarding SO- and gender-themed OCD can be similarly adapted for this presentation.

Considerations for Research

Given the need to integrate intersectionality, social justice, and diversity in psychology (Buchanan & Wiklund, 2020; Cénat, 2020), it is imperative that we consider these issues as they relate to the research of SO-OCD. It is necessary that we try to understand the prevalence of these other experiences, and how identification and assessment of these experiences may help further define differences, as well as how to treat these experiences by taking an inclusive, justice-oriented approach.

PREVALENCE RESEARCH

Prevalence and understanding of these types of OCD is extremely limited and likely underestimated (e.g., Pinto et al., 2008; Williams & Farris, 2011). As stated earlier, a case report on a client experiencing gender-related obsessions specifically cites only SO-OCD criteria and notes that there is limited evidence on gender-related OCD (Safer et al., 2016). It is also important to note that some research categorizes gender-related OCD as a sexual obsession, therefore conflating sexual experiences and gender identity (Safer et al., 2016). To date, this is one of the very few papers examining gender-related OCD (Aboujaoude & Starcevic, 2021; Uvais & Sreeraj, 2017; Williams & Ching, 2016).

We recommend gaining more accurate and inclusive information on who experiences SO-OCD and gender-related OCD. This may include large cross-sectional surveys specific to people with SO-OCD and gender-related OCD, as well as gathering reports from outpatient, residential, and inpatient treatment providers who have treated people with SO-OCD. This should also include gathering other relevant demographic information (e.g., age, gender, SO, race, ethnicity, geographic location). Additional information helpful for understanding prevalence may be examining client and provider perceptions of who typically seeks treatment for OCD compared to who typically seeks treatment for SO-OCD. It is possible that stigma and stereotypes are also preventing people from receiving accurate diagnoses.

ASSESSMENT RESEARCH

Related to furthering our general understanding and assessment of SO-OCD, it would be helpful for future research to differentiate the experience between sexual obsessions and general rumina-

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tions (regret associated with previous consensual sexual experiences, distorted thoughts related to self-view, such as "I am inferior to other people"; Williams & Farris, 2011). More empirical evidence identifying the differences between these two types of thought processes would help with further assessment and differentiating the nuance between the two experiences.

It would also be helpful to empirically differentiate the experiences of SO-OCD and the coming-out process (the contextual, ongoing, and evolving process of acknowledging and accepting one's SO, as well as sharing the identity with others; Klein et al., 2015; Luxon et al., 2021). Providing clearly distinct constructs between these experiences and having quantitative and qualitative data related to these constructs demonstrates how to assess, interpret, and approach the differences between someone who is experiencing SO-OCD and someone who is coming to terms with their SO. From this information, the creation of tested and validated tools or measures that could assist with differentiating would be beneficial for both research and clinical work.

TREATMENT RESEARCH

Regarding considerations for treatment research, although we believe that the treatment recommendations we provided above will be effective given that the underlying principles of how to conduct ERP and functional assessment of treatment targets are the same, we acknowledge that these recommendations have not been empirically tested. We provide the following recommendations for people to incorporate measurement into their already existing practice to gather real-world data, as well as recommendations for treatment outcome studies.

It would also be beneficial to assess clinician and client perceptions of our treatment suggestions in order to measure the feasibility and acceptability of using these suggestions in treatment. To assess whether our justice-oriented recommendations decrease homophobia, biphobia, and transphobia, it may be helpful to provide clients with measurements of bias against sexual and gender minorities prior to and after treatment. For example, providers who completed a clinical workshop specific to decreasing expressing biases and negative stereotypes when interacting with clients of color microaggressed less toward these clients, improved their emotional rapport with Black standardized clients, and improved their self-reported explicit attitudes toward people of color (Kanter et al., 2020). It is possible that taking a similar approach specifically to decrease bias toward sexual minorities for providers and clients may assist in reducing symptoms of SO-OCD, as well as reduce stigma against sexual minority communities.

Finally, we propose that our suggestions be tested empirically through treatment outcome research. This would range from empirical case studies, single-subject design studies, pilot studies, and randomized controlled trials. It would be beneficial to have empirical evidence that examines changes related to OCD symptoms and homophobic, biphobic, and transphobic beliefs as a result of our treatment suggestions.

INCLUSIVITY IN RESEARCH

Our final recommendation is related to inclusivity in research. We would argue that this paper and conversation is long overdue, and it is likely that it has not been written about due to a general lack of underrepresented people in psychology, including people with different sexual and gender identities other than heterosexual and cisgender. It would be beneficial to include people who identify as sexual and gender minorities and/or have expertise in sexual and gender minority-related issues on research teams studying SO- and gender-themed OCD. These scholars should either be protected if they speak up or be people in positions of power. It is often the case that people with marginalized identities are more junior on projects while the principal investigator is often someone who benefits from several societal privileges. At a minimum, when designing research questions and studies, we recommend that researchers consult with members of various sexual and gender minority committees (via topic experts, focus groups, etc.) to ensure that research questions are being asked in a way that does not perpetuate stigma and further marginalization of this group.

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Traditional SO-OCD Imaginal Exposure	Justice-Oriented SO-OCD Imaginal Exposure
Back in high school I was terrified about people thinking I was homosexual. I always put a great deal of effort into my appearance, hated sports, and was really into theater. Classmates would call me "gay" and "sissy," and because I was so effeminate, I wondered if they were right. Years later, I began dating a woman named Stacey. Things were great. I even lost my virginity to her, but still something was not right. These thoughts just would never leave me alone. I went to seek professional help for these stubborn worries, and I was diagnosed with H-OCD. The therapist had me doing all sorts of exposures to try and get rid of the worries that I might be homosexual—the therapy was going fine at first. She had me wearing feminine clothes like pink shirts, describing gay sexual acts in graphic detail, and talking to people who looked gay. Eventually, I started realizing that I was not anxious about doing these things. I actually liked it. I knew that Stacey would be hurt by this realization, but I also knew I had to stop living a lie. I have been "acting gay" all my life, and the therapy has taught me to embrace this new homosexual lifestyle, so I took it all the way.	Back in high school I was terrified about people thinking I was gay. I would see other guys in the hallways and try to figure out whether or not I found them attractive. If a friend mentioned something about being gay, I would constantly wonder if I was gay too or if they were talking about me. Years later, I began dating a woman named Stacey. Things were great. I even lost my virginity to her, but still something was not right. These thoughts just would never leave me alone. I went to seek professional help for these stubborn worries, and I was diagnosed with OCD. The therapist had me doing all sorts of exposures to try and get rid of the worries that I might be gay—the therapy was going fine at first. She had me looking at pictures of gay men and watching movies with gay people. Eventually, I started realizing that I was not anxious about looking at these things. I actually liked it. I knew that Stacey would be hurt by this realization, but I also knew I had to stop living a lie. I have been having images of sex with other men in my head any way, and the therapy has taught me to embrace these images, so I took it all the way.
Without Stacey knowing, I met up with some of the gay guys I had been avoiding, and we went to a gay bar. Surprisingly, I was not anxious at all. When the outing first started, I was bothered by the fact that Stacey thought I was somewhere else, but after an hour or so I realized she was not even on my mind. There were so many hot guys around and I loved imagining having sex with all of them. It felt so liberating to finally live this homosexual lifestyle I've always secretly wanted. I came to realize this entire time I had been running away from my true self despite the obvious red flags my whole life. The more I hung out with this one particular guy, the less and less I felt for Stacey. We went back to his place and had anal sex. The next day, I told Stacey about the affair and we got into a heated argument. She told me I was "disgusting" and I knew she was right. I can't believe I cheated on her—and with a man, no less. She quickly packed her things and stormed out of the house, and I was left feeling ashamed and disgusted with myself. I had given in to my homoerotic desires that I had spent so many years pushing down, and I would never forgive myself for that. After the breakup, all of my friends took Stacey's side and my parents told me that they were ashamed of me for what I had done. It was devastating to know that I would never be able to love a woman again and I feared I would spend the rest of my life alone.	Without Stacey knowing, I met up with some of the gay guys I had been avoiding, and we went to a gay bar. Surprisingly, I was not anxious at all. When the outing first started, I was bothered by the fact that Stacey thought I was somewhere else, but after an hour or so I realized she was not even on my mind. I was talking and flirting and standing really close with these guys—it felt so liberating to finally be having an evening not ruined by thoughts of being gay. I came to realize this entire time I had been running away from my true self. The more I hung out with this one particular guy, the less and less I felt for Stacey. We went back to his place and we had sex. I was nervous since this would be my first sexual encounter with a man but now that I can do it—I can honestly say I have never felt that way in bed with Stacey. It's not that I never loved Stacey, but now I know that she could never satisfy me sexually the way a man can. I have accepted the idea that I am gay, and while it used to make me sad to think that I could miss out on having a life with Stacey and children, I see now that if I allowed myself to go down that same path, I would also wonder about what it would be like to be gay. Now I can forget about all that because I was not living the life I was meant to live. I am now in a relationship with a man who satisfies me in ways a woman never could, and I will never go back. I ended up leaving Stacey after all because it was not right to lie to her any longer. I am so glad I went into treatment because if I had not gone through that, I would not have come to the realization that I am gay.

Note: Justice-oriented imaginal exposure adapted from Williams and Wetterneck (2019).

Conflict of Interest Statement

The authors declare that there are no conflicts of interest.

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