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How Do I Know I’m Not Really Gay? An Update.

By Fred Penzel, Ph.D.

O---ver the years, I have written quite a number of articles about different forms of OCD. Becau se the variations are endless, there always seemed to be a great hunger for information on the part of sufferers trying to understand what was happening to them, specifically.
Interestingly enough, the article that has always generated the most e-mails and phone calls was one titled, “How Do I Know I’m Not Really Gay?”
The OCF published this in their newsletter in 1995.
Back when I wrote this article, it was my belief that although no one had ever written about it, this form of the disorder was far more prevalent than most people realized.
The twelve years since then have convinced me even further that this is so.

Fortunately for sufferers, the general awareness of this type of OCD has increased over the years, and there is less of a sense of isolation than formerly. There are now several internet chat groups and bulletin boards that can be readily accessed, and a quick web search will turn up articles on the subject, where none existed in the past.
Within my own practice, there is rarely a time these days when I am treating fewer than six or more people for this form of the disorder.
I think it would be reasonable to say that after all this time an update might be in order.

OCD, as we know, is largely about experiencing severe and unrelenting doubt. It can cause you to doubt even the most basic things about yourself – even your sexual orientation. A 1998 study published in the Journal of Sex Research found that among a group of 171 college students, 84% reported the occurrence of sexual intrusive thoughts (Byers et al, 1998).
In order to have doubts about one's sexual identity, a sufferer need not ever have had a homo- or heterosexual experience, or any type of sexual experience at all. I have observed this symptom in young children, adolescents, and adults as well.
Interestingly, Swedo et al., 1989 found that approximately 4% of children with OCD experience obsessions concerned with forbidden, aggressive, or perverse sexual thoughts.

Although doubts about one's own sexual identity might seem pretty straightforward as a symptom, there are actually a number of variations. The most obvious form is where a sufferer experiences the thought that they might be of a different sexual orientation than they formerly believed. If the sufferer is heterosexual, then the thought may be that they are homosexual.
If, on the other hand, they happen to be homosexual, they may obsess about the possibility that they might really be straight.
Going a step beyond this, some sufferers have obsessions that tell them that they may have acted, or will act on their thoughts.
A variation on doubt about sexual identity would be where the obsessive thought has fastened onto the idea that the person simply will never be able to
*figure out*
what their sexual orientation actually is.
Patients will sometimes relate their belief that, "I could deal with whatever my sexuality turns out

to be, but my mind just won't let me settle on anything."
Some people's doubts are further complicated by having such experiences as hearing other people talking or looking in their direction and thinking that these people must be analyzing their behavior or appearance and talking about them – discussing how they must be gay (or straight).

For those with thoughts of being homosexual, part of the distress must surely be social in origin. Let's face it: gay people have always been an oppressed minority within our culture, and to suddenly think of being in this position and to be stigmatized in this way can be frightening. People don't generally obsess about things they find positive or pleasurable. I have sometimes wondered if those who experience the most distress from such thoughts as these do so because they were raised with more strongly homophobic or anti-gay attitudes to begin with, or if it is simply because one's sexuality can be such a basic doubt. I suppose this remains a question for research to answer. The older psychoanalytic therapies often make people with this problem feel much worse by saying that the thoughts represent true inner desires. This has never proven to be so.

Doubting something so basic about yourself can obviously be quite a torturous business. When I first see people for this problem, they are typically engaged in any number of compulsive activities, which may occupy many hours of each day.
These can include:

· Looking at attractive men or women, or pictures of them, or reading sexually oriented literature or pornography (hetero- or homosexual) to see if they are sexually exciting

· Imagining themselves in sexual situations and then observing their own reaction to them

· Masturbating or having sex repeatedly just for the purpose of checking their own reaction to it. (This may also include visiting prostitutes in more extreme cases)

· Observing themselves for evidence of "looking", talking, walking, dressing, or gesturing like someone who is either gay or straight.

· Compulsively reviewing and analyzing past interactions with other men or women to see if they have acted like a gay or straight person

· Checking the reactions or conversations of others to determine whether or not they might have noticed them acting inappropriately, or if these people were giving the sufferer strange looks

· Reading articles on the internet about how an individual can tell if they are gay or straight to see which group they might be most similar to

· Reading stories by people who “came-out” to see if they can find any resemblance to their own experiences

· Repeatedly questioning others or seeking reassurance about their sexuality

Compulsive questioning can frequently take place, and usually involves others who may be close to the sufferer. The questions are never-ending and repetitive. Some of the more typical questions sufferers are likely to ask can include those in the following two groupings:

For those who obsess about not knowing what their identity is:

· How do I know whether I prefer women or men?

· Maybe I really don't know what I am.

· Maybe I'll never know what I am.

· How does anyone tell what sex they really are?

· How will I ever be able to tell for certain?

· What will happen if I make the wrong choice and get trapped in a lifestyle that

really isn't for me?

For those who obsess that they are of the opposite sexual orientation:

· “Do you think I could be gay (or straight)?”

· “How can I tell if I'm really gay (or straight)?”

· “At what point in their lives do people know what their orientation is?”

· “Can you suddenly turn into a homosexual (or heterosexual) even if you have never felt or acted that that way?”

· “Did I just act sexually toward you?”

· “Do I look (or act) gay (or straight) to you?”

· “Did I just touch you?”

· “If I get sexual sensations when viewing sexual material of an opposite orientation does it mean I am gay (or straight)?”

In terms of the last question above, one of the most difficult situations for this group of sufferers is when they experience a sexual reaction to something they feel would be inappropriate. A typical example would be a heterosexual man who experiences an erection while looking at gay erotica.
It is important to note that it is extremely common for people to resort to all sorts of fantasy material concerning unusual or forbidden sexual behaviors that they would never actually engage in, but that they do find stimulating. Under the right circumstances, many things can cause sexual arousal in a person.

The fact of the matter is that people react sexually to sexual things.
I am not just talking about people with OCD here, but about people in general.
I cannot count the number of times that patients have related to me that they have experienced sexual feelings and feelings of stimulation when encountering things they felt were taboo or forbidden.
This, of course, then leads them to think that their thoughts must reflect a true inner desire, and are a sign that they really are of a different sexual orientation.
This reaction is strengthened by the incorrect belief that homosexual cues
*never*
stimulate heterosexuals.
One further complicating factor in all this is that some obsessive thinkers mistake feelings of anxiety for feelings of sexual arousal.
The two are actually physiologically similar in some ways.

Things become even more complicated by a number of cognitive (thinking) errors seen in OCD.
It is these errors, which lead OC sufferers to react anxiously to their thoughts, and then to have to perform compulsions to relieve that anxiety.
Cognitive OCD theorists believe that obsessions have their origin in the normal unwanted intrusive thoughts seen in the general population.
What separate these everyday intrusions from obsessions seen in OCD are the meanings or appraisals that the OCD sufferers attach to the thoughts.
As I like to explain to my patients, their problem is not the thoughts themselves, but instead it is what they make of the thoughts, as well as their attempts to relieve their anxiety via compulsions and avoidance.

Some typical cognitive errors made by OC sufferers include:

· I must always have certainty and control in life (intolerance of uncertainty)

· I must be in control of all my thoughts and emotions at all times

· If I lose control of my thoughts, I must do something to regain that control

· Thinking the thought means it is important and it is important because I think about it

· It is abnormal to have intrusive thoughts, and if I do have them, it means I'm crazy, weird, etc.

· Having an intrusive thought and doing what it suggests are the same, morally

· Thinking about doing harm, and not preventing it is just as bad as committing harm (also known as Thought-Action Fusion)

· Having intrusive thoughts means I am likely to act on them

· I cannot take the risk that my thoughts will come true

The effect of the questioning behavior on friends and family can be rather negative, drawing a lot of angry responses or ridicule after the thousandth time. One young man I know questioned his girlfriend so often that she eventually broke up with him and this added to his worries since he now wondered if she did so because he wasn't a "real man."

The compulsive activities sufferers perform in response to their ideas, of

course, do nothing to settle the issue. Often, the more checking and questioning that is done, the more doubtful the sufferer becomes. Even if they feel better for a few minutes as a result of a compulsion, the doubt quickly returns.
I like to tell my patients that it is as if that information-gathering portion of their brain is coated with Teflon©.
The answers just don't stick.

In addition to performing compulsions, one other way in which sufferers cope with the fears caused by the obsessions is through avoidance, and by this I mean directly avoiding everyday situations that get the thoughts going. This can involve:

· Avoiding standing close to, touching, or brushing against members of the same sex (or opposite sex if the sufferer is gay)

· Not reading or looking at videos, news reports, books, or articles having anything to do with gay people or other sexual subjects

· Never saying the words "gay," "homosexual," (or "straight") or any other related term

· Trying to not look or act effeminately (if a man) or in a masculine way (if a woman) (or vice versa if the sufferer is gay)

· Not dressing in ways that would make one look effeminate (if a man) or masculine (if a woman) (again, vice versa if the sufferer is gay)

· Not talking about sexual identity issues or subjects with others

· Avoiding associating with anyone who may be gay or who seems to lean in that direction (if the sufferer is heterosexual)

Needless to say, it is crucial for all OCD sufferers to understand that there is no avoiding what they fear. Facing what you fear is a way of getting closer to the truth.

The purpose of compulsions is, of course, to undo, cancel out, or neutralize the anxiety caused by obsessions. They may actually work in the short run, but their benefits are only temporary. O C sufferers cannot process the information they provide, and it just doesn't stick.
It is sort of like having only half of the Velcro.
Also, it is important to understand that compulsions are paradoxical – that is, they bring about the opposite of what they are intended to accomplish.
That is, to help the sufferer to be free of anxiety and obsessive thoughts.

I like to tell my patients that:

**"Compulsions start out as a solution to the problem of having obsessions, but soon**

**become the problem itself."**

What compulsions do accomplish is to cause the sufferer to become behaviorally addicted to performing them. Even the little bit of relief they get is enough to get this dependency going. C ompulsions only lead to more compulsions, and avoidance only leads to more avoidance.
This is really only natural for people to do.
It is instinctive to try to escape or avoid that which makes you anxious.
Unfortunately, this is of no help in OCD.

Another problem that arises from performing compulsions is that those who keep checking their own reactions to members of the opposite or same sex will inevitably create a paradox for themselves. They become so nervous about what they may see in themselves that they don't feel very excited, and then think that this must mean they have the *wrong* preference. When they are around members of their own sex, they also become anxious, which leads to further stress and, of course, more doubts about themselves.
The flip side of this is when they look at things having to do with sex of an opposite orientation and then feel aroused in some way, which they then conclude to mean that they liked it, which means that they are gay (or straight).
This is the mistake I referred to earlier when I stated that people react sexually to sexual things.

People like to ask if there are any new developments in OCD treatments. Aside from a few new medications since the last article, treatment remains essentially the same.
The formula of cognitive/behavioral therapy plus medication (in many cases) is still the way to go.
The particular form of behavioral therapy shown to be the most effective is known as Exposure and Response Prevention (E&RP).

E&RP encourages participants to expose themselves to their obsessions (or to situations that will bring on the obsessions), while they prevent themselves from using compulsions to get rid of the resulting anxiety. The fearful thoughts or situations are approached in gradually increased amounts over a period of from several weeks to several months.
This results in an effect upon the individual that we call "habituation."
That is, when you remain in the presence of what you fear over long periods of time, you will soon see that no harm of any kind results.
As you do so in slowly increasing amounts, you develop a tolerance to the presence of the fear, and its effect is greatly lessened.
By continually avoiding feared situations and never really encountering them, you keep yourself sensitized.
By facing them, you learn that the avoidance itself is the "real" threat that keeps you trapped.
It puts you in the role of a scientist conducting experiments that test your own fearful predictions, to see what really happens when you don't avoid what you fear.
The result is that as you slowly build up your tolerance for whatever is fear provoking; it begins to take larger and larger doses of frightening thoughts or situations to bring on the same amount of anxiety.
When you have finally managed to tolerate the most difficult parts of your OCD, they can no longer cause you to react with fear.
Basically, you can tell yourself, “Okay, so I can think about this, but I don’t have to do anything about it.”
By agreeing to face some short-term anxiety, you can thus achieve long-term relief.
It is important to note that the goal of E&RP is not the elimination of obsessive thoughts, but to learn to tolerate and accept all thoughts with little or no distress.
This reduced distress may, in turn, as a byproduct, reduce the frequency of the obsessions.
Complete elimination of intrusive thoughts may not be a realistic goal, given the commonality of intrusive thoughts in humans in general.

Using this technique, you work with a therapist to expose yourself to gradually increasing levels of anxiety-provoking situations and thoughts. You learn to tolerate the fearful situations without resorting to questioning, checking, or avoiding. By allowing the anxiety to subside on its own, you slowly build up your tolerance to it, and it begins to take more and more to make you anxious. Eventually, as you work your way up the list to facing your worst fears, there will be little about the subject that can set you off. You may still get the thoughts here and there, but you will no longer feel that you must react to them, and you will be able to let them pass.

There are many techniques for confronting sexual and other obsessions that we have developed over the years. Some of these techniques include:

· Listening to 2-3 minute audio recordings about the feared subject

· Leaving cell phone voice-mail messages for yourself about the feared subject

· Writing 2 page compositions about a particular obsession (and then taping them in your own voice)

· Writing feared sentences repetitively

· Hanging signs in your room or house with feared statements

· Wearing T-shirts with feared slogans

· Visiting locations that will stimulate thoughts

· Being around people who will stimulate thoughts

· Agreeing with all feared thoughts, and telling yourself they are true and

represent your real desires

· Reading books on the subject of your thoughts

· Visiting websites that relate to your thoughts

These are some typical exposure therapy homework assignments I have assigned to people over the years:

· Reading books by or about gay persons.

· Watching videos on gay themes or about gay characters.

· Visiting gay meetings, shops, browsing in gay bookstores, or visiting areas of town that are more predominantly gay.

· Wearing a T-shirt at home with the word ‘gay’ on it.

· Wearing clothes in fit, color, or style that could possibly look effeminate for a man, or masculine for a woman.

· Looking at pictures of good-looking people of your own sex and rating them on attractiveness.

· Reading magazines such as Playboy if you are a woman or Playgirl if you are a man.

· Standing close to members of your own sex.

· Doing a series of writing assignments of a couple of pages each that suggest more and more that you actually are gay or wish to be.

· Making a series of three-minute tapes that, based on the writings, gradually suggest more and more that you are gay, and listening to them several times a day, changing them when they no longer bother you).

Some typical response prevention exercises might include:

· Not checking your reactions to attractive members of your own sex.

· Not imagining yourself in sexual situations with same-sex individuals to check on your own reactions.

· Not behaving sexually with members of the opposite sex just to check your own

reactions.

· Resist reviewing previous situations where you were with members of the same or opposite sex or where things were ambiguous to see if you did anything questionable.

· Avoid observing yourself to see if you behaved in a way you imagine a homosexual or member of the opposite sex would.

Some typical exposure homework for those with doubts about their own sexual identity might include:

· Reading about people who are sexually confused

· Reading about people who are transgendered

· Looking at pictures of people who are transgendered or are transvestites

· Telling yourself and listening to tapes telling you that you will never really know what you are

Some corresponding response prevention exercises to go along with the above would be:

· Not checking your reactions when viewing members of either sex

· Not acting sexually to simply test your reactions

· Avoiding reviewing thoughts or situations you have uncertainty about

Many of the above therapy tasks can sound scary and intimidating. Obviously, you don't do these things all at once. Be
havioral change is gradual change.
Recovering from OCD is certainly not an easy task.
We rarely use the word 'easy' at our clinic.
It takes persistence and determination, but it can be done.
People do it all the time, especially with proper help and advice.
My own advice to those of you reading this would be to get yourself out of the compulsion trap, and get yourself into treatment with qualified people.

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