

**SEXUAL OBSESSION, RELIGIOSITY, CLINICAL
CORRELATES AND QUALITY OF LIFE AMONG PEOPLE
WITH OBSESSIVE-COMPULSIVE DISORDER (OCD)**

Thesis Submitted for the Award of the Degree of

DOCTOR OF PHILOSOPHY

IN

PSYCHOLOGY

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2025

DECLARATION

I solemnly declare that the research work presented in the thesis titled "**Sexual Obsession, Religiosity, Clinical Correlates, and Quality of Life Among Individuals with Obsessive-Compulsive Disorder (OCD)**", submitted in partial fulfilment of the requirements for the degree of **Doctor of Philosophy (Ph.D.)**, is the result of my independent research conducted under the supervision of **Dr. Zahoor Ahmad Lone**, Assistant Professor, **Department of Psychology**, Lovely Professional University, Punjab, India. Appropriate citations and acknowledgements have been provided wherever content is derived from the work of other scholars, by standard academic practice. I further affirm that this thesis has not been submitted, either in part or in full, for the award of any other academic degree or diploma at any university or institution.



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CERTIFICATE

This is to certify that the Ph.D. thesis titled “Sexual Obsession, Religiosity, Clinical Correlates and Quality of Life Among People with Obsessive-Compulsive Disorder (OCD)” submitted in partial fulfilment of the requirements for the award of the degree of Doctor of Philosophy (Ph.D.) in the Department of Psychology is the result of original and independent research work conducted by Ms. Ankuna Sharma, bearing Registration No. 12208580. The research was undertaken under my supervision, and to the best of my knowledge, the content of this thesis has not been submitted in part or full for the award of any other degree, diploma, or equivalent qualification.

Supervisor's Signature

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ABSTRACT

Obsessive-Compulsive Disorder (OCD) is a chronic psychiatric condition characterised by intrusive thoughts (obsessions) and repetitive behaviours (compulsions) that cause significant distress and impair daily functioning (American Psychiatric Association, 2013). Among the various OCD subtypes, sexual and religious obsessions remain underexplored, particularly in India, where cultural stigma often prevents open discussion (Rakesh et al., 2021; Shabnam & Mishra, 2020). The limited awareness of these subtypes has led to a gap in diagnosis and treatment. This study aims to investigate the prevalence of sexual and religious obsessions, their clinical correlates (anxiety and depression), and their impact on quality of life (QOL) among individuals with OCD. This research aims to explore the clinical profile of individuals with obsessive-compulsive disorder (OCD) who experience sexual and religious obsessions and to determine their effects on psychological well-being. It seeks to provide empirical evidence of the correlation of these obsessions with anxiety, depression, and overall quality of life (QOL). The findings contribute to the development of culturally aware interventions and add to the growing body of OCD research in India.

Objectives

1. To study sexual obsession in adults with OCD.
2. To identify religious obsession in adults with OCD.
3. To determine the clinical correlates (anxiety and depression) in adults with OCD.
4. To find the mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession with OCD.
5. To find the moderating effects of quality of life on people with sexual and religious obsessions in OCD.
6. To examine the gender differences in adults having a sexual and religious obsession with OCD.
7. To analyse the quality of life of people suffering from sexual and religious obsessions in OCD.

Hypothesis

Ho 1. There will be no sexual obsessions in adults with OCD.

Ho 2. There will be no religious obsession in adults with OCD.

Ho 3. There will be no clinical correlates (anxiety and depression) in adults with OCD.

Ho 4. There will be no mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession.

Ho 5. There will be no moderating effects on the quality of life of people with sexual and religious obsessions in OCD.

Ho 6. There will be no significant difference in adults having a sexual and religious obsession with OCD in relation to Gender.

Ho 7. There will be no significant difference in the quality of life of people suffering from sexual and religious obsessions with OCD.

This study employed a cross-sectional design to investigate sexual obsession, religious obsessions, clinical correlates, and quality of life in individuals diagnosed with OCD. A deductive methodology is utilised, progressing from established theoretical frameworks to specific hypotheses. Participants (N=100) were recruited from Ashoka Neuro Psychiatric Hospital & Addiction Centre, Jalandhar, Punjab, using a purposive sampling technique. All participants were diagnosed based on the criteria outlined in the DSM-5 (American Psychiatric Association, 2013) or ICD-10 (World Health Organisation, 1992).

Standardised psychological tools were employed to provide an in-depth assessment. The severity of obsessions and compulsions, as well as sexual and religious obsessions, was assessed using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) and the YBOCS Symptom Checklist (YBOCS-SC) (Goodman et al., 1989). The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1997) was used to assess the levels of anxiety and depression among participants. The WHO Quality of Life-BREF (WHOQOL Group, 1997) was used to evaluate different quality domains, including physical, psychological, social, and environmental well-being.

Inclusion Criteria

- People aged 18–40 years
- Primary diagnosis of OCD (DSM-5 or ICD-10).
- Patients from the psychiatric OPD and IPD.
- Both male and female participants.
- Minimum education level of upper primary.
- Able to be interviewed in person with the help of a Mini-Mental State Examination (MMSE).

Exclusion Criteria

- Individuals below 18 years.
- Participants with lower educational levels or illiterate individuals.
- Presence of organic mental illness.
- Inability to understand and provide informed consent.

Data was analysed using SPSS (version 26) and AMOS software (version 23). Descriptive statistics were used to determine the prevalence of sexual and religious obsessions. Pearson's correlation examined relationships between obsessions, anxiety, depression, and QOL. Structural Equation Modeling analysed the mediating effects of clinical correlates, while moderation analysis determined the role of QOL. Chi-square tests were used to compare gender differences in sexual and religious obsessions, and ANOVA tests evaluated differences in QOL among individuals with these obsessions.

Among individuals with OCD, 31% experienced sexual obsessions—13% reported them alone, while 18% experienced them alongside religious obsessions. 38% of participants reported religious obsessions, with 20% experiencing them exclusively and 18% combining them with sexual obsessions. Anxiety and depression emerged as significant clinical correlates, adversely affecting quality of life (QOL). Religious obsessions significantly predicted depression, partially mediated by depressive symptoms, whereas sexual obsessions did not show a strong association with either anxiety or depression. This suggests that internal factors such as stigma and shame may contribute more to the distress associated with sexual obsessions (Rakesh et al., 2021). QOL moderated the relationship between religious obsessions and OCD severity—likely due to more effective coping mechanisms and social support—but showed no

moderating effect in the case of sexual obsessions, possibly due to persistent guilt and societal stigma (Boger et al., 2020; Garg et al., 2023). No significant gender differences were observed in the prevalence or severity of sexual and religious obsessions, highlighting the importance of symptom-focused rather than gender-specific interventions (Barman et al., 2023; Steinberg et al., 2016). Moreover, individuals with sexual obsessions reported significantly lower QOL compared to those with religious obsessions, emphasising the need for targeted, sexuality-focused therapeutic approaches (Remmerswaal et al., 2016).

The findings emphasise the distressing nature of sexual and religious obsessions in OCD, with religious obsessions being significantly associated with depression, likely due to moral and existential concerns, while sexual obsessions are more influenced by cultural stigma. Despite a better quality of life (QOL) reducing distress from religious obsessions, it did not mitigate distress from sexual obsessions, suggesting that shame and guilt remain persistent factors. Individuals experiencing sexual obsessions reported the lowest quality of life compared to those with religious obsessions, highlighting the need for sexuality-focused therapy to address their distress effectively. Furthermore, the results underscore that anxiety and depression are significant clinical correlates of OCD, negatively impacting QOL. As no significant gender differences were found in the prevalence or severity of sexual and religious obsessions, interventions should prioritise symptom-focused approaches rather than gender-specific strategies. Treatment should be tailored to the individual's clinical presentation rather than based on gender differences. Exposure and Response Prevention (ERP) is highly effective for individuals with sexual and religious obsessions and should be prioritised in therapeutic approaches.

This study underscores the importance of thorough assessments of sexual and religious obsessions in OCD for accurate diagnosis and effective treatment. Cognitive-behavioural therapy (CBT) and ERP should be primary interventions, alongside stigma-reducing strategies to address societal and cultural barriers. Since sexual obsessions cause significant distress, treatment should incorporate techniques targeting guilt, shame, and identity conflicts. Integrating sociological and religious perspectives in therapy may enhance adherence, particularly in culturally diverse contexts like India.

Future research should focus on causal factors through longitudinal studies, exploring neurological and genetic underpinnings, and evaluating targeted therapeutic interventions. Developing culturally sensitive treatment models that integrate CBT, Acceptance and Commitment Therapy (ACT), ERP, and psychoeducation will be crucial for reducing stigma, improving mental health outcomes, and enhancing QOL for individuals with OCD.

Keywords: *Obsessive-Compulsive Disorder (OCD), Sexual Obsessions, Religious Obsessions, Anxiety, Depression, Quality of Life (QOL), Clinical Correlates, Mediation Analysis, Moderation Analysis, Cultural Stigma.*

ACKNOWLEDGEMENT

We conducted this study to examine the clinical profile of individuals with OCD who experience sexual and religious obsessions and their impact on psychological well-being. Understanding these effects can enhance diagnosis, treatment, and awareness by providing scientific evidence of their relationship to anxiety, depression, and quality of life. The successful completion of my research, titled 'Sexual Obsession, Religiosity, Clinical Correlates, and Quality of Life Among People with Obsessive-Compulsive Disorder (OCD)', was made possible through the support of many. I sincerely thank the Almighty for the strength, resilience, and patience that guided me throughout this journey.

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With gratitude,

Ankuna Sharma

Ph.D. Scholar

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List of Abbreviations	
Abbreviations	Full form
OCD	Obsessive-Compulsive Disorder
OCSDs	Obsessive-Compulsive Spectrum Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ICD-10	International Classification of Diseases, 10th Revision
ICD-11	International Classification of Diseases, 11th Revision
CBT	Cognitive Behavioural Therapy
ERP	Exposure and Response Prevention
ACT	Acceptance and Commitment Therapy
CT	Cognitive Treatment
APA	American Psychiatric Association
WHO	World Health Organization
WHOQOL-BREF	World Health Organization Quality of Life – BREF
QoL	Quality of Life
PERMA	Positive Emotions, Engagement, Relationships, Meaning, and Accomplishments
Y-BOCS	Yale-Brown Obsessive Compulsive Scale
Y-BOCS-SC	Yale-Brown Obsessive Compulsive Scale Symptom Checklist
HADS	Hospital Anxiety and Depression Scale
SEM	Structural Equation Modeling
ANOVA	Analysis of Variance

SPSS	Statistical Package for the Social Sciences
FFM	Five-Factor Model (of Personality)
SSRIs	Selective Serotonin Reuptake Inhibitors
MHPs	Mental Health Professionals
GAD	Generalised Anxiety Disorder
DD	Dysthymic Disorder
RDD	Recurrent Major Depressive Disorder
PD	Panic Disorder
SRO	Sexual and Religious Obsessions
RMSEA	Root Mean Square Error of Approximation
CFI	Comparative Fit Index
TLI	Tucker-Lewis Index
SRMR	Standardised Root Mean Square Residual
α (Alpha)	Cronbach's Alpha (for reliability)
β (Beta)	Standardized Regression Coefficient
r	Pearson Correlation Coefficient
df	Degrees of Freedom
M	Mean
N	Sample Size
CI	Confidence Interval
P	Probability Value

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CHAPTER – I

INTRODUCTION

CHAPTER - I

INTRODUCTION

1.1 Background of the Study

OCD (Psychoneurotic disorder) (Behera, 2013) is marked by Obsessions and compulsive behaviours that disrupt day-to-day activities. Obsessive-compulsive disorder (OCD) is characterised by two primary features: obsessions and compulsions. Obsessions are unwanted, intrusive, and persistent thoughts, ideas, or urges that cause significant distress. Compulsions are repetitive, ritualistic behaviours or mental acts performed to neutralise or avoid the discomfort and anxiety caused by these obsessions (American Psychiatric Association, 2013; Giasuddin & Hossain, 2020).

In the most recent version of the DSM, OCD is not classified as an anxiety disorder but is instead classified under obsessive-compulsive and related disorders (Ferguson, 2023). Despite this, people with OCD often experience extremely high levels of anxiety brought on by their obsessive beliefs. To mitigate this anxiety, they may engage in complex rituals. These persistent obsessions can manifest as intrusive emotions, thoughts, or sensations, driving individuals to engage in certain behaviours to alleviate their distress repeatedly (Kelly, 2019).

Many people experience intrusive and obsessive thoughts, but those who have OCD endure persistent ideas and rigidly enforced behaviours. Increased worry and suffering may arise from ignoring the obsessive thoughts or failing to carry out the behaviours. As a result, if OCD is left untreated, it can seriously hinder everyday tasks, regular functioning, and interpersonal relationships. A person with OCD frequently understand that their obsessive ideas are untrue, yet they nonetheless struggle to let go of these beliefs or cease their compulsive behaviours (Guy-Evans, 2021). OCD patients with limited insight often believe that their OCD-related thoughts and beliefs are likely or entirely true. This group constitutes approximately 13–36% of all OCD patients (Jacob et al., 2014; Huang et al., 2023)

According to the World Health Organisation, obsessive-compulsive disorder (OCD) is ranked among the top ten most disabling disorders globally, highlighting its significant impact on individuals' quality of life and functionality (World Health Organisation, 2001; Murray, 1996).

The National Comorbidity Survey Replication (NCS-R) indicates that the average age at which OCD first manifests is 19.5 years. Females are substantially more likely than men to experience OCD and vice versa (Ruscio et al., 2010).

The severity of OCD is further compounded by its high rate of comorbidity with other mental health conditions. According to DSM-5, men are more likely to have co-morbid tic disorders and experience OCD at a younger age than women (Bayırlı, 2013). Further anxiety disorders (such as the disorder of generalised anxiety and social anxiety) and mood disorders (such as major depression and bipolar disorder) frequently co-occur with OCD (Guy-Evans, 2021; Toprak, 2024). People with comorbid GAD were specifically associated with greater evasive behaviours, higher anxiety levels, panic disorder without agoraphobia, social phobia, and specific phobia, but they can also be associated with bipolar disorder and panic disorder. This demonstrates the necessity of diagnosing GAD in OCD patients (Sharma et al., 2021). Obsessive-compulsive spectrum disorder (OCSO), including Tourette's syndrome, shopping addiction, pathological gambling, pyromania, kleptomania, intermittent explosive disorder, self-destructive behaviour, and Compulsive sexual behaviour disorder (CSBD), is generally diagnosed through clinical interviews for OCSO. Comparing the prevalence rates of OCSO in men were far more likely than women to have Compulsive sexual behaviour disorder (CSBD) during their lives—5.6% of patients with present OCD had this condition (Fuss et al., 2019). These additional disorders exacerbate the challenges faced by those with OCD, often leading to more complex clinical presentations and complicating treatment efforts (Torres et al., 2006; Van Oudheusden et al., 2020; Toprak, 2024).

In addition to reducing OCD symptoms, cognitive therapy may also help with linked core beliefs, depression, and anxiety disorders (Steketee et al., 2011). In addition to medication, exposure and ritual prevention, a kind of cognitive behavioural treatment, are both efficient therapies for OCD (Williams et al., 2011). 4T model, the Vicious cycle of OCD and Thought-action fusion (TAF) are used to explain the process of obsessive symptoms by looking at their symptoms and offering new alternative interpretations (Toprak, 2024).

1.2 Clinical Syndromes

DSM -5

The American Psychiatric Association upgraded its classification and diagnosis tool from the DSM-4 (released in 2000) to the DSM-5 in May 2013. The DSM is the only recognised source in the United States for diagnosing various psychological illnesses, their treatment, and

payment by health care providers. As a result, the development of DSM-5 is of tremendous empirical significance not only in the United States but throughout the world, including India (Sen, 2013).

(A) Obsessions, compulsions, or both:

Obsessions:

1. Recurrent and persistent thoughts, desires, or ideas that are intrusive and unwanted, causing significant anxiety or discomfort in most people.
2. The individual attempts to ignore or hide these thoughts, desires, or ideas or tries to neutralise them with another behaviour or thought by doing a compulsion.

Compulsions:

1. Compulsions are defined as repetitive actions or thoughts that an individual feels compelled to perform due to an obsession or strict rules. Examples of these actions include hand washing, ordering, checking, praying, counting, and quietly repeating phrases.
2. These compulsions aim to prevent or reduce worry, and distress, or avoid a dreaded event or set of circumstances. However, these actions are not realistically associated with their intended purpose or are excessive.

Note: Young children may not be able to describe the goals of these behaviours or mental activities.

(B) If your obsessions or compulsions take up more than an hour of your day or are causing significant distress or difficulties in your social, work, or personal lives, it may be a sign that you need to seek professional help.

(C) The symptoms of obsessive-compulsive disorder are not a result of the physical impact of a substance like drugs, medicine, or any other medical condition.

(D) If a person experiences disturbance, it should not be attributed to any other mental disorder, such as worrying too much about small things (comes under generalised anxiety disorder), obsession with how they look (as in body dysmorphic disorder), trouble getting rid of things (as in hoarding disorder), pulling your hair (as in trichotillomania or hair-

pulling disorder), skin picking (as in skin-picking disorder), prejudices (as in stereotypic movement disorder), or consuming foods in a ritualized way. Some examples of mental health conditions include addiction to narcotics or gambling, anxiety disorder, a desire for sexual activity or fantasies seen within paraphilic disorders, impulsive behaviours observed in disorderly, impulse control, and conduct disorders, and guilty thoughts seen in major depressive disorder. Individuals with schizophrenia spectrum disorder as well as other psychotic conditions may experience thought insertion or delusional preoccupations. Similarly, individuals with autism spectrum disorder may exhibit repetitive patterns of behaviour.

Include If:

Individuals with decent or reasonable understanding are aware that their OCD beliefs may not be true or real, while those with inadequate or poor insight believe that their beliefs are likely to be true. Individuals lacking insight or delusional beliefs are entirely sure that their obsessive-compulsive disorder beliefs are correct.

Include If:

Tic-related: The person has a tic condition either in the present or in the past. (Bayırlı, 2013).

ICD

The abbreviation ICD refers to the International Classification of Diseases, which is used to classify accidents, diseases, and reasons for death Organisation (WHO) releases ICDs to establish a standard approach to gathering and monitoring cases of psychological disorders that have been identified globally. This allows researchers to examine diseases, their origins, and how they are treated. In 1992, the WHO first released ICD-10 (National Cancer Institute, 2015).

The ICD-10 classification of OCD divides it into three clinical subtypes:

The key characteristic of OCD, according to the International Classification of Diseases 10, is persistent obsessions with thoughts and compulsive behaviours. Obsessive thoughts are pictures, beliefs, and concepts that recur in a person's mind regularly. Obsessive-compulsive thoughts produce anxiety because they are violent or ignorant, or even because they are viewed as nonsensical, and the patient strives to avoid these kinds of thinking (Modi, 2016).

1. Mostly ruminative or obsessive thoughts.
2. Activities that are mostly compulsions.
3. Mixed Obsessional behaviours and thoughts.

Depression is frequently related to obsessive-compulsive disorder. It is believed that at least 50% of OCD sufferers have significant depression, even if many more have moderate depression. Premorbid obsessive or anankastic personality disorder or "traits" can be more frequent than in the general population (Narain, n.d.; World Health Organisation, 2011).

Modifications made to ICD-11 (in order to replace ICD-10):

- A summary of compulsions and obsessions. The phrase "impulses" in the definition of obsessions has been changed to "impulses or urges." At the same time, the term "repetitive behaviours, including continuous cognitive acts," has been added to the characterisation of compulsions.
- Demonstrating how compulsions and obsessions have a relationship (compulsions are frequently "performed in reaction to obsessive thoughts").
- The reduction of the time limit needed for diagnosis (in ICD-10, signs of obsessive-compulsive disorder must be present on the majority of days for at least two consecutive weeks). permitting an OCD diagnosis in the context of other diseases such as depression, schizophrenia, and Tourette's syndrome (In ICD-10, an OCD diagnosis cannot be given in the presence of concurrent depressive disorder, schizophrenia, or Tourette's syndrome.)

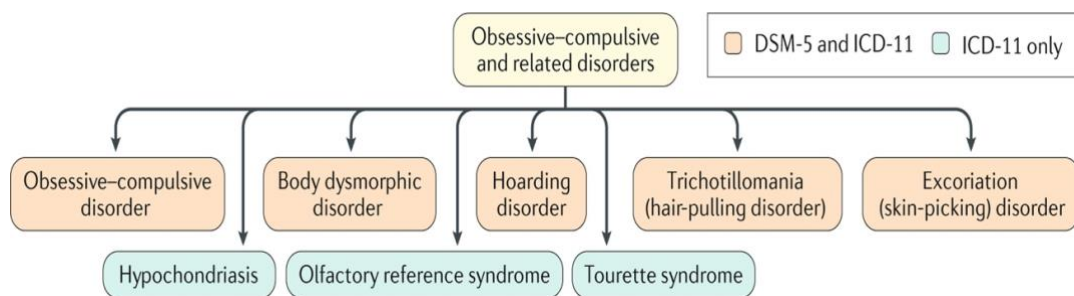


Figure 1.1| Obsessive-Compulsive and Related Disorder (Stein et al., 2019).

Image Source- <https://pubmed.ncbi.nlm.nih.gov/31371720/>

1.3 The History of OCD

The history of obsessive-compulsive disorder (OCD) shows how the disorder grew to be recognised as a separate psychiatric disease after it was first described as "scrupulosity" in religious contexts. The essay examines how, even before the disorder's current diagnosis, religious obsessions—a characteristic of OCD—were recorded in philosophical and theological works. Figures such as Jean Charlier de Gerson, Johannes Nider, Antoninus of Florence, and Saint Ignatius of Loyola are well-known for their writings on scrupulosity. They wrote about intense worry about sin and obsessive religious practices (OCD-UK, 2018).

Different perspectives, such as melancholy, "folie impulsive," and "madness of doubt," emerged as the understanding of OCD advanced. French psychiatrists like Jean-Pierre Falret and Bernard Augustin Morel played key roles in shaping these evolving concepts. Falret emphasised compassionate treatment for the mentally ill, while Morel delved into the emotional origins of the condition. In the late nineteenth and early twentieth centuries, OCD was initially considered a neurosis or degeneration. The German psychiatrist Karl Friedrich Otto Westphal's term "Zwangsvorstellung" and Sigmund Freud's psychoanalytic theory have influenced the current understanding of the condition. In particular, Freud connected OCD to inner conflicts and defence mechanisms, which contributed to the definition of the condition as obsessive-compulsive disorder (OCD) in the mid-twentieth century (OCD-UK, 2018).

The above text explores the complicated and developing understanding of OCD throughout historical periods and cultural contexts, demonstrating how the condition was viewed and treated before the present clinical diagnosis was formed.

1.4 Theoretical Framework of Obsessive-Compulsive Disorder (Sexual Obsession, Religiosity, Clinical Correlates and Quality Of Life)

1.4.1 Interactionist Approach

The nature vs. nurture argument asks whether our characteristics are biologically predetermined (nature) or whether they result from environmental factors (nurture). The argument in favour of nature contends that characteristics, behaviours, and problems are brought on by biological predispositions associated with our genes, brains, or physiology.

The interactionist method uses both nature and nurture theories to explain behaviour. Developed in 1934 by philosopher George Herbert Mead. Understanding social interactions and symbolic interactions was the fundamental goal of this theory.

How Nature affects Nurture there are 3 different forms of genome-environment interactions that were recognised by Scarr & McCartney (1983): Passive: our biological parents create the surroundings for us, Reactive: Our personality may affect how other people view us, which in turn impacts our experiences and Active: Our biological predispositions and temperament affect the kind of surroundings we prefer.

Interactionism can be linked with obsessive-compulsive disorder because many mental illnesses are caused by environmental factors (nature) and biological factors (nurture), and OCD can be one of them. (*Interactionist Approach: Definition & Examples, Psychology*, n.d.)

1.4.2 Labelling Theory

An approach used in sociology for studying unacceptable behaviour (deviant behaviour) in society, called "labelling theory", stresses how people with social control include stigmatising stereotypes with specific groups and how stigmatised individuals modify the way they act as a result.

According to Howard Becker's (1963) concept, labels or outside evaluations have a detrimental effect on a person's sense of self and how they are seen by others. A person's interactions with and labels assigned by others play a major role in how they view themselves, according to the symbolic interactionism school, which gave birth to the labelling theory.

In other words, it is possible for a deviant label, such as being a criminal, to finally take in a person's whole identity. People usually dislike and reject persons with past criminal behaviours, and others may believe that criminals are not ethically capable of doing what is right (Nickerson, 2021).

Labelling theory and OCD might be related as there are many obsessions associated with OCD, such as religiosity and taboo thoughts, which are all stigmatised by society and cause disgust, distress, poor self-esteem, self-doubt, ruminating of thoughts, and other negative emotions.

1.4.3 Biological Theory of OCD

According to scans, surgical, and lesion research, particularly on the orbitofrontal and anterior cingulate cortices, the prefrontal cortex, basal ganglia, and thalamus may be involved in the

root cause of obsessive-compulsive disorder (Huey et al., 2008). The biological aetiology of OCD has been identified as the brain circuit that governs primal components of our behaviour, such as aggressiveness, sexuality, as well as bodily waste. This circuit delivers signals from the thalamus to the caudate nucleus of the brain's basal ganglia and other regions of the brain. Once you get connected with this circuit, these impulses are brought to your notice and cause you to respond in a particular way to deal with the impulse.

As an example, you need to clean your hands after using the loo to get rid of any potentially harmful bacteria. When you finish the needed action, in this case, cleaning your hands, the impulse from this brain circuit fades away, and you continue with your day.

It has been hypothesised that individuals with OCD have trouble telling their brains to ignore or turn off the electrical signals from this neural network, which results in repetitive actions known as compulsions as well as uncontrolled thoughts known as obsession. For example, your brain may struggle to switch off thoughts of contamination after exiting the loo, which may make you clean your hands constantly (Modi, 2016).

1.4.4 Cognitive Behaviour Model of OCD

The majority of cognitive theorists think that people with obsessive-compulsive disorder have false beliefs and that OCD results from their misunderstanding of intrusive thoughts. According to the cognitive model of OCD, every person often has anxious thoughts. OCD patients, however, usually have an overblown sense of duty and feel that these ideas are of extreme significance, which might have catastrophic consequences (OCD UK, 2018). Having intrusive thoughts, images, impulses, and doubts is quite frequent and entirely normal (Purdon & Clark, 1993, 1994). The event or content of intrusions is frequently interpreted as one of the following by people with OCD: believing that they are individually responsible for averting damage to themselves or others, that something awful has happened to them, or that something bad will happen (Salkovskis et al., 1998).

1.4.5 The Purpose of the Cognitive Behaviour Model

Models of psychological disorders were viewed by Gelder (1997) as wide, all-encompassing theoretical plans for organising information. The consistency of the obsessional themes—aggression, blasphemy, and sexuality—as well as why 90% of individuals report having intrusive thoughts with the same content, but only 2% to 3% exhibit clinically severe signs of OCD (Rachman & de Silva, 1978; Krochmalik & Menzies, 2003). The cognitive-behavioural model of OCD is that the mechanisms that could stop the onset of an illness, how to prevent it

from happening, and how to avoid relapsing after effective treatment can all be learned through understanding how a disorder develops.

1.4.6 The Behaviour Model of OCD

Approaches: The two-factor model of anxiety and avoidance, put forward in particular, served as the foundation for the behavioural theory of OCD (Mowrer, 1939, 1960). According to this paradigm, anxiety increases when an intrusive idea arises because intrusive thoughts, images, or impulses are often associated with anxiety through classical training. By avoiding stimuli that cause obsessional thoughts, the person subsequently learns through operant training to minimise obsessional worry. As a result, obsessive behaviour is used to overcome obsessive worry and is negatively rewarded by bringing about a reduction in anxiety. Additionally, the obsessive anxiousness never disappears completely. Solomon & Wynne (1954) used a series of dog experiments to show that escaping as well as avoiding reactions to classical conditioning stimuli were very invulnerable to extinction and persisted long after the link of conditioned stimuli to unpleasant consequences had discontinued. Additionally, the avoidance and escape reactions turned into stereotypical behaviours that were similar to the obsessive behaviours that were observable in OCD patients (Shafran, 2006).

1.4.7 Compulsive Checking According to A Cognitive Theory

In-depth cognitive research on obsessive checking was recently given by Rachman (2002). According to this theory, obsessive checking occurs in persons who believe they have a certain kinds of special duty to protect others from harm and have doubts about whether the threat still exists or has been lessened.

1.4.8 Cognitive Theory Discusses the Importance of Thought Control (Purdon And Clark, 2002)

According to the pathophysiology of obsessional disorders proposed by Purdon and Clark (1999), (a) false ideas about the significance of managing one's thoughts and (b) unfavourable misinterpretations of the results of failing to control unwanted intrusive thoughts are both essential. Faulty beliefs include things like "I must control every thought that enters my mind, especially negative ones (Purdon & Clark, 2002). Actively fighting with such thoughts, such as by making an effort to suppress them ('Shafran, 2006').

Role of schemas: Schemas frequently interfere with cognitive processes (a mental framework of beliefs and expectations developed from experience). These develop into more complex and in-depth as you get older. A "packet" of knowledge or cognitive framework is referred to as a schema. The way in which humans organise and comprehend knowledge that they have inherited from their ancestors is known as a schema (McLeod, 2020).

1.4.9 Psychodynamic Theory

The Austrian psychotherapist Sigmund Freud, who founded the field of psychoanalysis, gradually created an OCD theory based on his ideas on mental structure, mental energy, and defence mechanisms. According to Freud, when the patient's unconscious, undesirable sexual or aggressive id impulses clash with the demands of conscience and reality, the patient's mind reacts in an unhelpful way. He thought the signs of the disorder, such as obsessive-compulsive behaviour, were caused by unconscious conflicts (OCD-UK, 2018). Psychodynamic theorists, people are conflicted beings. Because they believe that early relationships and painful experiences that occurred when they were youngsters are connected to psychological disorders, they are interested in looking back in time. Psychodynamic theories are based on the deterministic concept that past experiences shape all behaviour and that no symptom or action is "accidental" (Shukla, 2022).

Freud created the concept of psychoanalysis to explain both normal and deviant psychological functioning and a correlating therapeutic approach, a conversational technique now known as psychoanalysis, using this earlier research as a foundation.

Freud developed the psychosexual stage of personality development, he said that a person may become fixated, or stuck, at any time, which could hinder later development and lead to deviant behaviour or psychopathology.

Freud's Psychosexual stage:

- 1. Oral stage:** The libido is concentrated in the mouth during the oral stage (from birth to 24 months). Sexual tension can be eased by chewing and biting as baby teeth erupt after first sucking and swallowing. Fixation is linked to low self-esteem, arguing, and sarcasm.
- 2. Anal stage (between 2 to 3 years):** The anus is the object of libido attention when toilet training happens during the anal stage. If the parents are overly liberal, children could become disorganised or messy. If the mother is extremely strict about toilet training, the kid might hold back faeces and get constipated. As a result, an anal-retentive personality

develops (Mcleod, 2019). Having extremely strict parents may cause children to become obstinate. The OCD symptoms that stem from instinctive desires and prohibition are those that are most noticeable in the anal stage of development.

- 3. Phallic Period (3–5 or 6 years):** During this stage, children form a connection with the parent of the opposite sex and harbour envy towards the parent of the same sex. The genitalia is the focal point of the libido. Boys who suffer from Oedipus complexes fall in love with their mothers and are terrified that their fathers will find out and castrate them, which develops castration anxiety in boys. Penis envy: girls who fall in love with their father often worry that their mother will know about it, which is known as the "Electra complex". The girl finds that she does not possess a penis like her father, and she blames her mother for this. As much as she loves her father, she hates her mother. Castration Complex is the collective word for penis envy and castration anxiety (Mcleod, 2019). A preoccupation at this moment might result in an inability to value oneself, shyness and worthlessness
- 4. Latent stage (6–12 years):** During the latency stage, males play with boys and girls play with girls as a result of the children's loss of interest in sexual activity. Neither sex is particularly interested in the other.
- 5. Genital Stage 12 (puberty):** of the genitalia Sexual urges reawaken starting in adolescence, and lovemaking can sate unmet cravings from early childhood and infancy (Shukla, 2022).

Sexual obsession in OCD can be linked with this theory as the study investigated that the adverse early childhood experiences such as parental abandonment, mother–father disputes, and lack of affection and attention from parents lead to fixation in the stage of psychosexual development, It further encourages the adoption of inappropriate defence mechanisms, which in turn encourages the development of obsessive personality traits (Choudhary et al., 2022).

Religiosity can have a relationship with the structure of personality. Freud believed that the id, ego, and superego are what give rise to our personality, which are the three components of our personality.

Id: The id is the impulsive, aggressive, and sexually inclined aspect of each of us. Since it is already there at birth, completely unconscious, as well as based on the pleasure principle, It causes us to act selfishly and chase fleeting pleasures at all costs.

The ego: The Ego, the second part of the personality, arises through early life events that shape who we are. The ego tries to maintain a balance between urges, necessities of reality, and ultimately, the superego's moral values. The reality principle underlies its operation, as does the realisation that behaviours must be modified in order to fulfil environmental needs.

The superego: The superego is the final part of the personality to develop. It represents societal norms, ethical norms, legal constraints, and our sense of morality. When we recognise that many of our id's wants are wrong, we end up accepting our parents' principles. Even so, we sometimes break these boundaries and feel shameful about it. Our moral consciousness is a tiny part of the superego that is mostly subconscious but also somewhat aware.

These sexual obsessions are also being consciously neutralised or suppressed. OCD with sexual orientation is typically characterised by unpleasant intrusive sexual ideas and ego-dystonic sexual content, which may include thoughts about inappropriate sexual behaviour, child abuse, anxieties or thoughts regarding one's sexual orientation, or thoughts about having sex with family members and aggressive sexual behaviour (e.g., with children, animals, or inanimate objects (Choudhary et al., 2022).

1.4.10 Theory of the Five-Factor Model of Personality

Paul Costa and Robert McCrae investigated every personality attribute that may exist. The results point to five distinct causes. They are commonly referred to as the "Big Five Factors." Such traits are frequently classified as either positive or negative (Cherry, 2023).

- 1. Openness to experience:** People who score high on this criterion are creative, curious, open to new ideas, and engaged in cultural activities. Those who score low, on the other hand, are strict.
- 2. Extraversion:** It describes people who are socially engaged, strong, outgoing, conversational, and enjoy themselves. People who are shy are the complete opposite.
- 3. Agreeableness:** People who are agreeable are helpful, cooperative, kind, compassionate, and nurturing. People who are aggressive and self-centred are the exact opposite.

4. **Neuroticism:** People with high levels of neuroticism are emotionally unstable, nervous, concerned, scared, agitated, irritable, and hypertensive. People who are well-adjusted are on the other end of the spectrum.
5. **Conscientiousness:** Those with a high level of conscientiousness are goal-oriented, dependable, responsible, careful, committed, and self-controlled. People who are impulsive are the total opposite.

This five-factor model is a significant theoretical advancement in the study of personality (National Council of Education Research and Training, 2007). As we all know, obsession with perfection, order, and hygiene are characteristics of OCD, a personality disorder. People suffering from obsessive-compulsive personality disorder (OCPD) are likely to experience a strong urge to enforce their own rules on others around them (Watson, 2012).

This theory can be linked to religious obsession in OCD patients because many people with neurotic personalities are emotionally unstable, anxious about things like repetitive praying, concerned about moral values, and fearful, and they tend to be irritable and hypertensive most of the time (Bilekli & Inozu, 2018).

1.4.11 Freud Discussed Ego-Defence Mechanisms

Freud observed that after encountering these kinds of obsessions in OCD, people use ego defence mechanisms which are intended to keep them protected from anxiety, but are judged maladaptive if they are overdone and used as the major technique for reducing stress. The following are some of them: suppression, denial, regression, sublimation, projection, response creation, displacement, and rationalisation (Shukla, 2022). OCD is an overactive defence mechanism that interferes with a person's mental health system. This is a result of the distress and worry brought on by ruminative, obsessive thoughts and repetitive, compulsive actions (*Obsessive-Compulsive Disorder: Diagnosis and Treatment*, 2019).

1.4.12 Theory of Diathesis-Stress Model

The **diathesis-stress model** can be linked to clinical correlates (Anxiety and Depression) since it is the most commonly accepted explanation for abnormal behaviour. This disorder has three components: biological abnormality that may be inherited, vulnerability (the person is at risk of developing the illness), and pathogenic stressors that may lead to psychopathology. People are more likely to develop a disorder when exposed to certain stressors. It also explains why some people develop psychiatric problems after being exposed to a stressor. This concept has

been used in disorders such as depression, anxiety, panic attacks, and schizophrenia (National Council of Education Research and Training, 2007).

1.4.13 Beck's Theory

Beck's theory is directly connected to clinical correlation, especially depression. This is because cognitive and behavioural factors in individuals with OCD can trigger depression. Aaron Beck characterised depression in cognitive terms, claiming that it is associated with a cognitive triad (bad feelings about oneself, the world, and the future) (Beck & Greenberg, 1984).

The depressed individual perceives the world via an organised collection of depressive schemata that distort unpleasant experiences about the self, the world, and the future (Beck, 1987). Schemas are subconscious thoughts that impact how people interpret their experiences (Kring et al., 2012). They differ from conscious thinking. When the individual is confronted with a scenario comparable to the one that led the negative schema to emerge, the schema activates. Once the schema is active, it is believed to generate cognitive biases, which refers to the tendency to interpret information in negative ways (Kendall & Ingram, 1989). (Shah, 2020). (Beck & Greenberg, 1984) suggested that individuals with depression may be overly sensitive to negative input while disregarding positive feedback about themselves. Those experiencing depression tend to make cognitive errors that result in biased judgments. These findings support the idea of an underlying negative framework that perpetuates a vicious cycle (Kring et al., 2012). According to studies, individuals with depression tend to focus on and remember more negative information than positive information when they encounter unpleasant stimuli (Gotlib & Joormann, 2010; Mathews & Macleod, 2002; Shah, 2020).

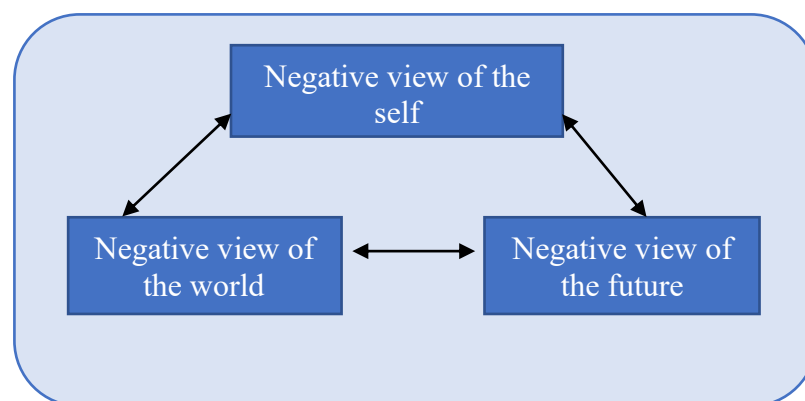


Figure 1.2 |: *Cognitive Triad (Shah, 2020).*

Figure source-
<http://hdl.handle.net/10603/448048>

1.4.14 Theory of Hierarchy of Needs by Abraham Maslow

A theory of quality of life (QOL) based on Abraham Maslow's human developmental viewpoint is put forward (Sirgy, 1986). In his 1943 work, Abraham Maslow developed the theory of a hierarchy of needs (Cherry, 2022).

- 1. Psychological needs:** Physiological requirements include those required for survival. Physiological needs include basic nourishment, air, and temperature regulation. Shelter and clothes are further examples of physiological demands. Maslow put sexual reproduction at this level of the hierarchy as well, because it is necessary for species survival and propagation.
- 2. Security and safety needs:** The needs grow more complicated on the second level of Maslow's hierarchy. At this level, the requirement for security and safety takes precedence. People desire order and control in their lives. Some of the most fundamental security and safety requirements are as follows: Financial security, health and well-being, and protection from accidents and injuries.
- 3. Social needs:** Maslow's hierarchy of needs includes love, acceptance, and belonging. At this level, human behaviour is driven by the need for emotional connections. It is critical for people to feel liked and accepted by others in order to avoid loneliness, sadness, and anxiety.
- 4. Needs for Self-Esteem:** The fourth level of Maslow's hierarchy of needs is the desire for recognition and respect. Once the conditions for the first three stages are met, esteem will begin to play a bigger role in motivating behaviour. People who are self-confident are able to satisfy their esteem demands by gaining high self-worth with the acknowledgement of others. Individuals who lack self-esteem and respect from others might experience feelings of inferiority. As a result, people may have a reduced quality of life during this time.
- 5. Needs for Self-Actualisation:** Maslow's hierarchy places needs for self-actualisation at the very high. Self-actualising individuals are self-aware and interested in improving themselves, less anxious about the opinions of others, and engaged in achieving their greatest potential in reaching their full potential. According to Maslow's hierarchy, at this

moment in time, the individual's quality of life is at its height, and the person is very happy. Quality of life is defined as the hierarchical need satisfaction level of the majority of people in a particular community (Sirgy, 1986). The higher the majority's need for satisfaction in a particular society, the better the society's QOL. According to Maslow's hierarchy, it is critical to satisfy this lower level in order to avoid negative emotions or consequences (Cherry, 2022).

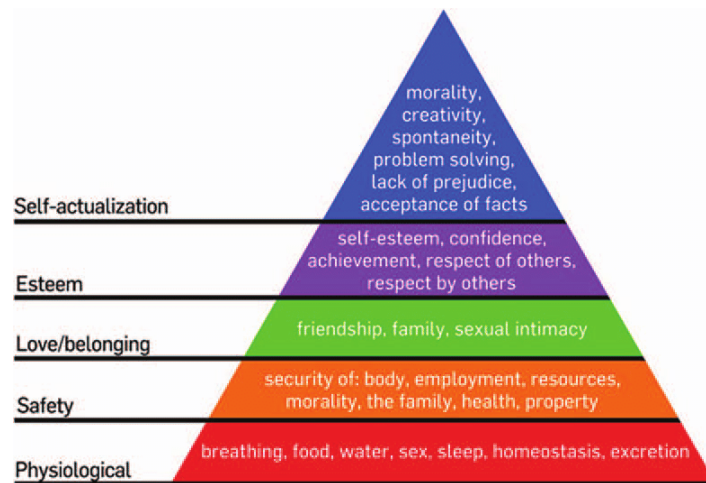


Figure 1.3| *Hierarchy of Needs by Abraham Maslow (Uchejeso et al., 2019)*

Figure Source- <https://www.researchgate.net/publication/331000757>

It is believed that improvements in QOL are followed by hierarchical changes in these societal structures (Sirgy, 1986). So, if we wish to enhance the quality of life of persons with OCD, it is critical to keep Maslow's hierarchy of needs in mind while diagnosing OCD, since these needs can interrelate and can decline the quality of life among OCD patients.

1.4.15 Theory of Parma Model of Wellbeing

Martin Seligman created the PERMA model to conceptualise the primary variables that contribute to happiness (Seligman, 2012). PERMA components have been linked to better health and life satisfaction in studies (Kern et al., 2014; Madeson, 2017). Based on this, it can enhance the quality of life of people who suffer from OCD.

The term PERMA stands for the following five aspects of well-being:

- Positive feelings, such as being upbeat and feeling content in the present while also being grateful for the past and hopeful about the future,
- Engagement refers to the state of being fully immersed in enjoyable activities and achieving a state of complete "flow".
- Relationships or establishing social bonds with family and friends.
- Meaning, or discovering a greater purpose in life than yourself
- Accomplishments, or aims and achievements (Cherry, 2019).

Positive psychology can possibly be applied in many different types of everyday situations, including learning, counselling, self-improvement, stress reduction, and job opportunities (Cherry, 2019). In comparison to past measures of psychological distress, PERMA is a better predictor of psychological distress (Forgeard et al., 2011). This shows that taking care of PERMA components not only enhances well-being but also minimises mental stress.

The key principles of positive psychology are strengths, beliefs, and self-love, which will provide you with the resources to improve the health of patients, youths, or workers (Madeson, 2017). This model can be linked with this theory in order to improve the quality of life, which will help us treat OCD patients.

1.5 Conceptual Framework of Obsessive-Compulsive Disorder

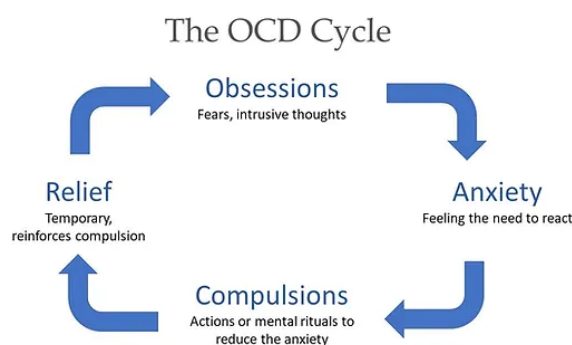


Figure 1.4| *The OCD cycle (LPC, 2018).*

Figure Source-<https://www.souletherapy.com/single-post/how-to-tell-if-you-have-ocd-and-what-to-do-about-it>

1.5.1 Obsession: Concept and Definition

A dreaded consequence frequently surfaces in OCD, obsessive thoughts. The feared result will differ depending on the sort of preoccupation experienced. One could be afraid of losing something significant, of upsetting someone, or of their safety or the safety of others they care about (Kelly,2019).

It is possible for these obsessions to get so intense that they obsessively engage in certain behaviour. These obsessions are frequently time-consuming, upsetting to the person who has them, undesired, and uncontrollable. Even though many OCD sufferers are aware of the unreality of their thoughts, they remain illogical and unsolvable. By ignoring or repressing their obsessions or by diverting their attention, people may attempt to reduce their discomfort, but this frequently leads to increased anxiety and misery (Kelly,2019).

1.5.2 Types of OCD

There are several ways in which obsessive-compulsive disorder can manifest. Some people just have compulsions, some only have obsessions, and some people have both. Although there are no recognised subtypes of OCD, the following are the most often-seen obsessions and compulsions: fear of contamination or cleanliness, an obsession with precision, symmetry, taboo thoughts, or hoarding (collecting)(Kelly,2019).

1. **Harm:** Obsessive thoughts of harming oneself or others are common in certain people. Since they were being reckless, they inadvertently inflicted this injury, which was not done on purpose. Some of the obsessive thoughts could revolve around repeated doubts about whether the house's doors are locked. Compulsions like checking repeatedly to see if the oven is off or that the doors are locked might develop from this sort of obsession.
2. **Contamination:** Those who are obsessed with contamination typically have a higher risk of sickness, dust, and germs. They could worry about acquiring other people's or the environment's contamination. The fear of handling objects that others have touched could be the subject of their obsessive thoughts.
3. **Physical illness:** Individuals who struggle with this fixation worry excessively about getting sick. They may be overly conscious of their internal functions, including breathing.

Obsessions with health, sickness or pain may develop as a result of these somatic obsessions.

4. **Sexual obsession or unwanted sexual thoughts:** People who have OCD may have excessively compulsive thoughts about unwanted or deviant sexual ideas. These ideas, which may be about child abuse, sexual aggressiveness, or inappropriate thoughts about minors, can be quite unpleasant.
5. **Religiosity:** People who are religiously fixated may have compulsive thoughts, fears, or worries about moral judgment. They could worry excessively about upsetting religious institutions. If they practise religion, they can be concerned about offending God or committing blasphemy (Deibler, 2022).
6. **Scrupulosity:** Scrupulosity is a psychological condition that is extremely distressing and maladaptive and is largely defined by pathological guilt or fixation related to moral or religious matters, that is frequently accompanied by obsessive moral or religious practice. This is similar to religiosity (Miller & Hedges, 2008).
7. **Perfectionism:** Excessive attention to precision and symmetry may be a symptom of perfectionism-related obsessions. They can worry about things not being organised in a certain manner or act compulsively to make things seem "just perfect." This could also entail stroking or caressing things until they feel comfortable doing so. Some people may be excessively fixated on the idea of unintentionally upsetting someone, leading them to behave impulsively and say or do inappropriate things or steal things.
8. **Losing control:** Some people may be excessively fixated on the idea of unintentionally upsetting someone, leading them to behave impulsively and say or do inappropriate things or steal things. They could frequently see violent or horrifying images in their minds. They could consider swearing or behaving badly in front of others. These ideas may make them worry that they may become uncontrollable.
9. **Superstitious belief:** People will go to great measures to complete an action a specific number of times for their fortunate number, for example, seven times by turning a light switch on and off before leaving a room. Suspicion-related obsessions are common among

OCD sufferers. This may have something to do with fortunate or unlucky words, items, colours, and numbers. People who believe something to be unfortunate may experience intense anxiety and make an effort to avoid it.

Obsessions	%	Compulsions	%
Fear of contamination	61	Cleaning & washing	50
Aggressive thoughts, images & impulses	43	Ordering	41
Need for symmetry	35	Repeating	38
Sexual	31	Checking	18
Religion	30	Hoarding	7
Pathological doubt	21	Miscellaneous	41
Miscellaneous	40		

Figure 1.5| Prevalence of Obsession and Compulsion Symptoms from the Indian Perspective (Khanna & Reddy, 2003)

Figure source -

https://www.academia.edu/1185548/Obsessive_Compulsive_Disorder_Indian_Perspective

1.5.3 Compulsion: Concept and Definition

Obsessive thoughts in OCD lead to compulsive behaviours. In reaction to an obsession, people may feel compelled to engage in repetitive behaviours or mental processes.

These compulsions are used to avoid or decrease the discomfort brought on by the fixation. These compulsions are performed to avoid or decrease the discomfort brought on by the obsession. According to the OCD sufferer, the compulsions may involve repetitive behaviour that interferes with daily life or serves as a protection against negative outcomes. These behaviours could have little to do with real obsessions, but if a person engages in them often enough, they may become "stuck" in them. Individuals can create rituals and regulations that they must follow. Commonly, compulsive behaviours only temporarily reduce anxiety and hardly provide any pleasure. Washing and cleaning, Checking, Orderliness and Counting are some of the compulsions (Guy-Evans, 2021).

1.5.4 Sexual Obsession: Concept and Definition

Sexual obsessions are usually called autogenous obsessions, which means they develop on their own. These people are afraid of taking risks and are not realistic, so they are considered extremely hazardous. A person suffering from a sexual obsessional disorder might be anxious about the meaning driven by thoughts that involve himself or herself, for example, 'if I have these thoughts, it means that I am a paedophile', behavioural implications, for example, 'I am going to molest someone', or moral consequences, for example, 'such thinking is sinful; God will punish me (Kuty-Pachecka, 2021).

People with strong and unusual sexual ideas on a regular basis may have a sexual obsession, which is frequently misdiagnosed. Obsessive-compulsive disorder (OCD), which affects 1 in 40 people, is a mental illness that includes several types of obsessions, including sexual obsessions (Hart, 2020). Approximately 6% to 24% of people with OCD will have some form of sexual obsession (Kunde, 2022).

The term "sexual obsession" has several different meanings. The most common one is the recurrent thought of homosexuality. A straight woman may become fixated on becoming a lesbian. She may have all the proof she needs to be sure she is straight—she has always had crushes on male movie stars, and she could even be dating someone—but she starts to wonder what would happen if she turns out to be homosexual. Is it possible that I'm lesbian because I'm attracted to that female?

There's also a chance that a child worries about engaging in unwanted sexual behaviour. A simple example of this would be worrying that he could have become angry after accidentally bumping into a peer in a crowded place. Or he might always be fearful of committing rape. He has no desire to rape somebody, but he feels uneasy at the notion of it. He could keep his hands in his pockets while walking and maintain a larger distance from others than is typical to minimise the chance that he would say or do something inappropriate.

The fear of holding unwanted sexual impulses, such as those for paedophilia or incest, is another concern for those with sexual obsessions. They are troubled by the thought that they may, even if, unlike the previous cases, they don't feel these impulses. Adolescents prefer to avoid their family members and children in the family, and they live alone most of the time (Ehmke & Bubrick, 2021).

Sexual obsessions are characterised by intense feelings of anxiety, concern, shame, and self-disgust, as opposed to pleasurable sexual fantasies. These ideas may make you feel anxious and negative at the same time. You probably live in continual fear that one day your intrusive thoughts about sex may drive you to act on your urges.

However, the reality is that OCD sufferers are the least likely to act on their sexual obsessions since their own thoughts really make them feel humiliated and repelled. Such conduct is seen as unethical, and they wish to repress their opinions. Instead of pursuing self-gratification, they are looking for an end to their anxieties. If you suffer from sexual OCD, you may turn to masturbation and pornography as coping mechanisms for your anxiety related to unwanted sexual thoughts (Kunde, 2022).

Common sexual Obsessions in OCD: There are several typical obsessions that OCD might be linked to, including:

- Extreme fear of being pulled toward a family member, pet, inanimate object or dead people, or young children.
- Severe fear of immoral sexual behaviour.
- Extreme anxiety about developing sexual violence.
- Intrusive thoughts and pictures might be brought on by images or ideas that indicate painful sexual behaviours involving unfavourable creatures (such as children or animals) (Mehta, 2022).

They frequently have the following thoughts:

- What happens if I start to get feelings for that person?
- What happens in case I lapse into immoral sexual behaviour?
- What if I expose my genitalia to others?
- What if I'm actually interested in having sex with that person?

Types of Sexual Obsessions and Thoughts in OCD

- The fear that one is or will become a paedophile (Parents frequently worry about being attracted to their own children sexually).
- The fear of developing a sexual attraction to animals.
- The concern of developing a sexual attraction to the dead.

- Aversion to being straight or fear of turning homosexual (if gay)
- Concerns about having a homosexual secret (or being straight) could also be present.
- Anxiety over being attracted to religious people sexually.
- Anxiety over being attracted to God sexually.
- Aversion to siblings, parents, or other family members on a sexual level.
- Aversion to acting aggressively or violently while having sex (J. Seay, n.d.).

1.5.5 Religiosity: Concept and Definition

According to Shafranske & Maloney (1990), religiosity is defined as respect for the practises and beliefs of an established church or religious institution. According to Hackney & Sanders (2003), "Religiosity is a multi-layered concept with cognitive, emotional, motivational, and behavioural aspects,". According to Allport & Ross (1967), there are two basic characteristics of religiosity: extrinsic and intrinsic. Both viewed extrinsic religiosity as a self-serving and practical understanding of religion that makes conversion easier for the believer. These people are willing to use religion to achieve their goals, such as status, sociability, and self-justification, and they frequently adapt their beliefs to match their goals.

The impact of religiosity and guilt in OCD has been extensively researched in the literature, indicating that higher levels of religiosity/spirituality, paranormal beliefs, and magical thinking are commonly connected with increased obsessive-compulsive behaviour. India is a multi-religious country, so it is especially significant that a study is necessary to evaluate the impact of religiosity and shame in the symptoms and outcomes of OCD, a disorder in which religious themes are frequently prominent, according to Rakesh et al. (2021).

Individuals with intrinsic religiosity internalise every aspect of their beliefs and go beyond conventional church attendance. These people find their life's main goal in religion, and their other demands match up with their religious beliefs. This theory says that "A person who is extrinsically motivated uses their religion to achieve their goal, whereas a person who is intrinsically motivated lives their religion" (Kazmi, 2019).

OCD is a widespread condition with several subtypes; in the case of religious OCD (also called scrupulosity), the individual is obsessed with obsessions that are founded in religion and/or religious beliefs or around convictions about morality. This type of OCD is characterised by compulsive religious rituals, avoidance, reassurance seeking, unwelcome blasphemous ideas and imagery, as well as obsessive religious concerns and worries.

Religious OCD patients have a strong belief in and fear of punishment from a deity or supernatural being. According to experts, between 5% and 33% of OCD sufferers may exhibit scrupulosity, and this percentage is likely to increase to between 50% and 60% among those who originate from extremely rigid religious environments. Because they are concerned about compromising their morals or accidentally upsetting others, even those who are not highly religious might struggle with scrupulosity. People with scrupulosity feel their ideas are the same as their acts, thus, they worry not just about what they have done but also about what they have thought, which is a frequent theme throughout the spectrum.

Scrupulosity and other obsessive-compulsive symptoms are predicted by neuroticism and the level of religiosity. These variables also predict obsessive beliefs, which are strongly correlated with shame and self-punishment (Bilekli & Inozu, 2018). The DSM-5 states that some people with OCD have poor insight or even delusional OCD beliefs (Bayırlı, 2013).

Religious behaviour such as:

- Repeating a prayer when feeling distracted or unable to focus properly.
- Checking one's behaviour repeatedly throughout the day to ensure they acted "correctly."
- Seeking reassurance from others multiple times to confirm that their behaviour was appropriate.
- Reading or studying religious books or texts excessively, more than usual.
- Doubting one's own intentions and questioning whether the motives behind actions were correct.
- Excessively apologising to God or asking for forgiveness many times. (Rosen, 2014).

1.5.6 Clinical Correlates (Anxiety And Depression): Concept and Definition

Anxiety: The American Psychological Association states that stress, disturbing thoughts, and bodily changes, such as an increase in blood pressure, are characteristics of anxiety. Anxious or intrusive thoughts are common among those with anxiety disorders. Out of anxiety, they would try to stay away from particular situations. They could also exhibit physical symptoms, including shaking, sweating, disorientation, or a rapid heartbeat. Fear is not the same as anxiety, despite the fact that the phrases are sometimes used together (American Psychological Association, 2022). Anxiety is different from fear, yet the terms are frequently used interchangeably. Anxiety is a deep-rooted, challenging reaction to a disorderly risk, whereas fear is a natural, present-oriented, and quick reaction to a clearly identified and specific fear (American Psychological Association, 2022).

OCD and anxiety are both mental health issues. The American Psychiatric Association (APA) previously defined obsessive-compulsive behaviour as one of various anxiety disorders. The American Psychiatric Association (APA) then recognised OCD as a completely different mental health condition in 2013 (Catchings, 2024).

What's the difference between anxiety and OCD? While both mental health illnesses include persistent worrying, individuals with obsessive-compulsive disorder (OCD) frequently engage in undesired and repetitive behaviour in defence of their anxiety. For example, someone with OCD may be terrified of catching an illness or infection. To cope, individuals may wash their hands over 100 times every single day or avoid contact with others. People who suffer from anxiety, on the other hand, tend to overthink their worries and do not respond in precise ways. For example, they would not feel compelled to wash their hands more than "normal" to ensure appropriate cleanliness. They'd also surely be okay shaking someone else's hand. OCD patients' brain chemical makeup differs greatly from that of anxiety patients. For example, we know that people with OCD frequently have low levels of serotonin, a neurotransmitter that is important for mood and sleep control (Catching, 2024).

OCD is not classified as an anxiety condition. However, OCD is frequently accompanied by intense anxiety (Ferguson, 2023). Although people who have it regularly have intrusive thoughts that can be distressing and interfere with everyday life. People may participate in rituals or repeat acts, and if they fail, they may become more concerned. Washing, cleaning, inspecting, sorting, and organising goods are common practices. Separate from OCD, other anxiety disorders encompass several factors, including Panic disorder, anxiety about social situations, generalised anxiety disorder, and phobia-related disorders are all examples of anxiety disorders (Villines, 2022).

Depression: Clinical depression and major depressive disorder are mood-related psychiatric illnesses marked by persistent melancholy and loss of interest. It affects how you think, feel, and act and can result in several mental and physical illnesses. It may be quite difficult for someone to go about their normal tasks while also believing that life isn't worth living (Sawchuk, 2022).

Some patients with obsessive-compulsive disorder may have depressive symptoms. OCD can occur without being depressed; however, it's normal for some OCD sufferers to additionally have depressive symptoms. When you have clinical depression, you experience persistent

melancholy for weeks or months, which can interfere with your professional, social, and familial lives. Depression is more than just feeling gloomy or frustrated for a few days. Numerous aches and pains, poor sleep, a lack of food, or a lack of sexual drive are examples of physical symptoms. People may experience any or all of the different signs and symptoms of depression, such as persistent feelings of melancholy or depression (OCD UK, 2013).

Feeling numb and alone, having difficulties with one's self-worth, continual ripping out, guilty feelings, being distressed Lacking drive for or interest in hobbies and interests, Having trouble making decisions that are not authentic in life, Having restless or anxious feelings, thoughts of self-harm, or suicidal emotions Low sexual desires, a general lack of energy, a loss of appetite, sleep issues, avoiding social situations, and trouble sustaining family ties. Depression treatments are quite similar to OCD treatments, with Cognitive Behavioural Therapy (CBT) being the most effective. Some people find that antidepressant medications help them control their symptoms (OCD UK, 2013).

1.5.7 Quality of Life: Concept and Definition

Quality of life is a concept that refers to the well-being of a community or a person in terms of their existence at a certain time in both good and bad ways. For instance, typical aspects of quality of life include a person's well-being on all levels, including physical, mental, and spiritual connections, education, occupation, economic status, finances, sense of security and safety, liberation, autonomy in making decisions, social connections, and the surrounding atmosphere (Teoli & Bhardwaj, 2022).

OCD may have different effects on people. Some people can find it difficult to leave the house or do everyday duties because they spend a significant amount of their days satisfying a variety of compulsions. Others can appear to be handling everyday routine, but a tremendous lot of sorrow is being felt as a result of obsession. Some OCD patients may carry out their compulsions and rituals secretly or create excuses to avoid social interaction so they can finish them (OCD UK, 2018a).

Obsessive-compulsive disorder (OCD) has a large illness burden and has a significant impact. To properly comprehend the magnitude of the impact of OCD on the patient population, one must consider not only the constant symptoms that haunt the patients but also their overall capacity to enjoy life. Quality of life (QOL) (Macy et al., 2013).

1.6 Statement of the Problem

Obsessive-compulsive disorder (OCD) is a chronic mental health condition marked by persistent, intrusive thoughts (obsessions) and repetitive behaviours (compulsions) aimed at reducing distress (American Psychiatric Association, 2022). Among its various symptom dimensions, sexual and religious obsessions are particularly distressing and can significantly impact an individual's well-being.

OCD is often associated with comorbid conditions such as depression, anxiety disorders, and sexual dysfunctions, influenced by guilt, shame, societal norms, and cultural expectations (Ghassemzadeh et al., 2016). Individuals with OCD generally experience a poorer quality of life compared to those without the disorder (Macy et al., 2013). In India, cultural taboos surrounding sexual issues may lead to reluctance to discuss or seek help for such obsessions. Research indicates that patients with recurrent major depressive disorder (RDD) exhibit higher rates of sexual and religious obsessions (Hong et al., 2004), and those with OCD and sexual obsessions are more likely to experience distress, violent tendencies, magical thinking, compulsive rituals, and a need for reassurance (Cruz et al., 2013). Given the severity of these symptoms and limited awareness, further research is essential to enhance understanding and develop specialised treatment approaches for individuals with sexual and religious obsessions in OCD.

1.7 Research Objectives and Hypotheses

Objectives:

1. To study sexual obsession in adults with OCD.
2. To identify religious obsession in adults with OCD.
3. To determine the clinical correlates (anxiety and depression) in adults with OCD.
4. To find the mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession with OCD.
5. To find the moderating effects of quality of life on people with sexual and religious obsessions in OCD.
6. To examine the gender differences in adults having a sexual and religious obsession with OCD.
7. To analyse the quality of life of people suffering from sexual and religious obsessions in OCD.

Hypothesis: (Null hypothesis)

Ho 1. There will be no sexual obsessions in adults with OCD.

Ho 2. There will be no religious obsession in adults with OCD.

Ho 3. There will be no clinical correlates (anxiety and depression) in adults with OCD.

Ho 4. There will be no mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession.

Ho 5. There will be no moderating effects on the quality of life of people with sexual and religious obsessions in OCD.

Ho 6. There will be no significant difference in adults having a sexual and religious obsession with OCD in relation to Gender.

Ho 7. There will be no significant difference in the quality of life of people suffering from sexual and religious obsessions with OCD.

CHAPTER – II
REVIEW OF
LITERATURE

CHAPTER - II

REVIEW OF LITERATURE

OCD is widely recognised as a neuropsychiatric disease. The medical condition known as obsessive-compulsive disorder (OCD) is widespread and chronic, which can lead to significant impairment worldwide. OCD is part of a group of disorders referred to as "obsessive-compulsive and related disorders," which are now defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, as well as the International Classification of Diseases, Eleventh Revision. Unfortunately, these disorders are often misdiagnosed or undertreated (Stein et al., 2019).

2.1 Comprehensive Insights into Obsessive-Compulsive Disorder: Sociodemographic Factors, Prevalence, and Clinical Characteristics

Baranova et al. (2024) studied the influence of education, IQ, and income on psychological disorders using sample sizes ranging from 9,907 to 807,553. The findings revealed that the individual effects of different psychosocial factors on mental disorders are complex. While higher educational attainment (EA) and IQ may have a negative impact on certain mental health conditions, higher wealth seems to be protective. The results from Mendelian randomisation (MR) analysis showed that higher EA helps protect against eight mental illnesses while also being associated with anorexia nervosa, OCD, bipolar disorder (BD), and autism spectrum disorder (ASD). Similarly, a higher IQ protects against five mental diseases but is linked to an increased risk of OCD and autism. The study suggests that the direct effects of EA, intellect, and wealth on mental illnesses warrant further investigation.

OCD is a condition that involves experiencing unwanted and repetitive thoughts, as well as engaging in behaviours or rituals that feel necessary to alleviate anxiety. Research indicates that OCD impacts between 1% and 3% of individuals, typically emerging during adolescence or early adulthood. Without proper treatment, OCD can become a chronic condition or worsen over time (Cervin, 2023).

Barman et al. (2023) investigated the pattern of obsessive and compulsive symptoms distribution across two genders in the Bengali community with obsessive-compulsive disorder. The sample was taken from a tertiary care hospital's psychiatry outpatient clinic, aged 18 to 59

years, with 50 male and 50 female consenting Bengali patients with obsessive-compulsive disorder. The findings indicate that, following cultural standards and the social role of society, symptoms of obsession and compulsion are frequently seen to be significantly different amongst male and female genders. The results showed that there were some persistent variations between both genders in the prevalence of obsessive and compulsive symptomatology. The study suggested that more research on phenotypic, biological, genetic, familial, neurological imaging, and neuropsychological aspects of OCD symptoms may contribute to our knowledge of its gender variations.

Lima et al. (2023) look at the clinical features of people with obsessive-compulsive disorder from both simplex and multiplex families. Researchers examined 994 OCD patients (501 multiplex and 493 simplex). The findings show that both hereditary and non-genetic variables contribute to obsessive-compulsive disorder (OCD), with considerable evidence of familial clustering. Multiplex probands had an earlier beginning, more severe sexual/religious and hoarding characteristics, more comorbidity with other obsessive-compulsive-related disorders (OCRD), and a greater family history of psychological disorders than simplex probands. Suggestion Distinct clinical patterns may indicate various genetic and environmental effects. More study is needed to better understand these disparities, which have consequences for symptom monitoring and therapy.

Mathis et al. (2011) explored gender differences in the clinical, genetic, and familial aspects of obsessive-compulsive disorder (OCD) using studies from Medline and PsycINFO over 20 years. Of 487 studies, 63 were analysed, revealing that male patients often experience earlier onset, chronic course, social impairment, and higher rates of sexual-religious obsessions, aggressive symptoms, and comorbid tic and substance use disorders. At the same time, females show more contamination/cleaning symptoms and comorbid eating or impulse-control disorders. Although genetic findings were inconclusive, gender was found to influence OCD expression. Tailored treatment is recommended, and further research should examine genetic, socio-cultural, and treatment response differences.

Until around two ages ago, obsessive-compulsive disorder was believed to be a rare condition. However, there has been a substantial advancement in our understanding of biology, multiple medical conditions, aetiology, signs and symptoms, epidemiology, and therapy for OCD. Recent findings suggest that attention is also being paid to a category of related disorders

known as obsessive-compulsive spectrum disorders. Researchers from the National Institute of Mental Health and Neurosciences (NIMHANS), introduced in Bangalore, have reviewed all relevant Indian data on OCD. Currently, there is only one epidemiological study conducted in India. In India, there has only been one epidemiological study conducted on obsessive-compulsive disorder (OCD). The study found that 0.6% of OCD patients had experienced the disorder throughout their lifetime. The study also identified the primary characteristics of OCD patients, which included washing, checking, hoarding, and two pure obsession elements. The obsessive groups in the study were mainly dominated by sexual and religious themes. Unfortunately, there is limited evidence from India on the therapeutic elements of OCD. However, a current study on a range of OCD-related issues, including clinical characteristics, biology, and medical care, is being carried out at NIMHANS in Bangalore (Reddy et al., 2010).

2.2 Studies Related to Sexual Obsession in Obsessive-Compulsive Disorder

The term "sexual obsessions" in obsessive-compulsive disorder (OCD) refers to intrusive and unwanted sexual thoughts and imagery. According to Kutty-Pachecka (2021), approximately 16.8% of OCD patients experience these types of obsessions. These thoughts cover a wide range of unwanted and distressing sexual concerns, including worries about family or children, anxieties about sexual orientation, thoughts about engaging in sexual activity with animals, or concerns about behaving sexually aggressively. According to several studies, 20% to 30% of OCD patients report having sexual obsessions (Rasmussen and Tsuang, 1986). Sexual obsessions in OCD patients have been observed in children as well (Swedo, 1989), and in some cases, they have been linked to prior sexual abuse (Freeman and Leonard, 2000; Shabnam and Neelam Mishra, 2020). Relevant and important research has been conducted to understand the current state of sexual obsessions in individuals with OCD.

(Surlles, 2024) explores sexual OCD, a manifestation of obsessive-compulsive disorder (OCD) characterised by intrusive sexual thoughts and related compulsions. Though not a formal diagnosis, sexual OCD describes OCD subtypes like paedophile OCD (POCD), sexual orientation OCD (SO-OCD), relationship OCD (ROCD), and transgender OCD (TOCD), often overlapping with harm OCD. Compulsions may involve mental rituals such as praying or ruminating and physical acts like checking sensations, avoiding triggers, or tapping. Sexual OCD underscores the diversity of OCD presentations and coping behaviours. Clinicians should

focus on treating the core mechanisms of OCD rather than specific subtypes. Future studies should examine treatment efficacy and cultural influences on sexual obsessions.

Psychodynamic view of OCD patients' sexually obsessive thoughts. The findings indicate that there are numerous subtypes of OCD, including sexual OCD, which is the presence of sexually intrusive ideas. A family member, inanimate objects, animals, God, or children may be the subject of unwanted obsessive sexual thoughts in those who suffer from sexual OCD. These ideas can differ in severity between mild and severe. The study uses a case study methodology while examining a diagnosed case of OCD to describe the viewpoint from psychodynamic theory on the causes of sexual obsessions. The result showed that experiences from childhood like parental abandonment, the dispute between mother and father, and a lack of affection from the parents and care cause fixation during phases of psychosexual development, which further causes the adoption of maladjusted defence mechanisms, which in turn furthers the evolution of obsessional personality tendencies. According to the investigation, there is a strong link between personal characteristics, the defensive mechanism, and the rise of obsessive symptoms (Chaudhary et al., 2022).

Research on sexuality, obsession, and compulsive disorder was conducted. The goal of this research is to review the literature on sexual behaviour, sexual dysfunctions, and the neurobiology of sexual dysfunctions in anxiety disorders generally and OCD specifically. The research focuses on sexual obsessions, symptoms of OCD that are connected to relationships, and how well relationships work with patients with OCD who are in ongoing medical care. The finding revealed that one of the more common mental conditions is obsessive-compulsive disorder (OCD). There hasn't been a lot of research on sexuality in OCD patients, despite the fact that it is one of the basic elements of biology. The sexual functioning of OCD individuals has not received much study. Research suggests that when treating OCD patients, we should constantly consider their sexual lives and cognitive executive functions (Koolwal et al., 2022).

Patients in the 16–60-year age range who reported they had OCD were included in the sample. Findings showed that insight is defined as being aware of one's emotional and psychological issues. Understanding the senselessness of the symptoms is known as insight in OCD. But there isn't much information on the subject—just a few studies from our geographical region have been published. According to the results, most of the individuals were working females between the ages of 21 and 30. Most of the participants have strong insight. For those who were obsessed with dirt and contamination, it was perfect; for those who were obsessed with

sexuality, it was the worst. Patients with excellent insight had higher disease severity, whereas those with low insight had longer mean illness durations and more coexisting illnesses. Conclusion: It was discovered that a lower prognosis for disease, greater severity, and a longer mean duration of illness were all positively connected with poor insight (Verma et al., 2022).

Sexual obsessions are common clinical aspects of OCD that emerge from sex-related symptoms. The study included 11 individuals with symptoms that persisted for over a year. The findings indicate that there has been a lack of formal research on sexual obsession in OCD. The results indicated that the patients have an obsession with sexual behaviours and experience discomfort if they are unable to manage their sexual impulses, which affects their personal and social functioning. Additional research in this area is required, according to the findings, and it should repeat studies that found clinical correlations between sexual obsessions and OCD patients (Shabnam & Neelam Mishra, 2020).

In comparison to individuals with other symptoms, OCD patients with contaminated or cleaning symptoms showed decreased sexual interest. The total number of samples taken was 72 (27 with signs of contamination or cleaning versus 45 without). According to the findings, people with OCD who had dirt or cleaning symptoms and higher levels of disgust showed a propensity to restrain themselves more because of the risk of having a poor sexual experience and its repercussions. It is possible that high sensitivity to disgust is a cause of the reduction in this area of well-being. The recommendation indicates that sexual health needs to be assessed as part of normal clinical assessments of individuals with OCD (Pozza et al., 2020).

Childhood abuse has been linked to developing and maintaining obsessive-compulsive disorder. A total of 68 OCD patients were included in the clinical sample. According to the findings, childhood abuse in OCD patients is related to increased symptom severity and poorer treatment outcomes. Neglect, sexual misconduct, and emotional assault are all prominent in our group. Furthermore, the level of experienced childhood maltreatment was connected with increased OCD symptom severity, with emotional abuse having the highest connection. According to hierarchical linear models, patients who experienced childhood maltreatment exhibited greater levels of OCD symptoms in the past treatment and during a follow-up of the treatment than clients who did not. As per the study's results, childhood maltreatment is common among OCD patients and childhood trauma survivors had greater OCD symptom

severity following therapy. As a result, childhood abuse should be included in psychiatric treatment for those with OCD (Boger et al., 2020).

Obsessive-compulsive spectrum disorders (OCSDs) and behavioural addictions both share certain clinical characteristics with compulsive sexual behaviour disorder (CSBD). 539 people between the ages of 18 and 75, including 260 men and 279 women, served as the study's sample population. The finding showed that OCSDs, including kleptomania, pyromania, intermittent explosive disorder, self-injury behaviour, Tourette's syndrome, excessive gambling, compulsive shopping, and other behaviours, are generally diagnosed through clinical interviews for OCSDs. Comparing the prevalence rates of OCSDs in male and female patients as well as comorbid illnesses in OCD patients with and without CSBD. The result revealed that CSBD was significantly more common in men than in women during their lives—5.6% of patients with present-day OCD had this condition. Individuals with lifetime CSBD had considerably higher lifetime prevalence rates for a number of mood disorders, obsessive-compulsive disorders, and impulse-control disorders. The conclusion says that the majority of OCD patients had CSBD. In addition, we discovered that, in contrast to behavioural or substance addictions, patients with OCD were more likely to have CSBD to co-occur with further impulsivity, compulsivity, and mood disorders. This outcome is consistent with the idea that compulsive-impulsive disorder (CSBD) exists (Fuss et al., 2019).

Sexual behaviour can develop if the person has substance and gambling addictions. Findings revealed that it is common that drug use disorders and compulsive sexual behaviour may be triggered by neurological mechanisms. Compulsive Sexual behaviour is a feature of hypersexuality. The result and conclusion indicate that, although there are still a lot of unknowns, it is possible that CSB and drug addictions can be treated with medical and psychotherapy approaches. Despite the rising numbers of studies connecting compulsive sexual behaviour to drug addictions, there are still many unanswered questions that make it difficult to classify CSB as a dependence (Kraus et al., 2016).

A case study to analyse sexual thoughts or obsessions in OCD with paraphilias and nonparaphilic sexual disorders. A sample was gathered from 29-year-old single men. The findings indicate that thoughts about sexuality in paraphilias and other nonparaphilic sexual disorders may not be upsetting to the person having them, in opposition to sexual impulses in OCD, which are deeply upsetting. Feeling distressed is not a valid diagnosis differentiator, which is a concern because incorrect diagnoses are frequently made. The results and

conclusions indicated that mental health practitioners should be able to detect or distinguish repeated sexual thoughts in paraphilias and nonparaphilic sexual-related disorders from persistent sexual obsessions in obsessive-compulsive disorder (Vella-Zarb et al., 2017).

Steinberg et al. (2016) Conducted research on 110 professionals and 66 graduate students. The finding revealed that people with obsessive-compulsive disorder experience constant intrusive thoughts that are so distressing that they make it difficult for them to go about their regular lives. The result concluded that when stigma prevails among mental health professionals, it could be problematic as it might lead them to distance themselves from their patients and have a pessimistic view of treatment results. Most often, mental health professionals may harbour biases toward those who have other mental problems. The study showed that participants were less likely to disclose having a sexual obsession to others than they were for the other three types of obsessions and that they were more inclined to socially reject or be worried by those with contaminating, hurting, or sexual obsessions than those with scrupulous obsessions. Obsessions with violent and sexually intrusive ideas are stigmatised by the majority of people. So, those with this sort of fixation strive to conceal it. Suggestions concluded that clinicians need greater training and expertise to educate people so that this stigma can be reduced.

The study sought to compare impulsive characteristics in OCD patients with sexual, religious, and aggressive obsessions to those with other obsessions and healthy controls. The findings showed that OCD patients with sexual, violent, and religious obsessions had substantially higher BIS-11 attention levels than other OCD patients and controls. The results revealed that individuals with OCD may have higher levels of attentional impulsivity, indicating a potential brain-related issue. The study recommends further research using advanced neuropsychological tests to explore clinical characteristics, neurobiology, and treatment outcomes in OCD (Sahmelikoglu Onur et al., 2016).

Bhatia et al. (2015) studied extreme anxiety of becoming or being gay characterises gay obsessive-compulsive disorder (HOCD). The participants frequently have disturbing, unpleasant mental images of homosexual activity. Excessive, uncontrolled thoughts and doubts are extremely stressful and lead to compulsions such as checking. We describe a unique instance of a person suffering from HOCD. Obsessions with sexual objects are a typical sign of obsessive-compulsive disorder. Many people with this kind of OCD get misdiagnosed since there are no accurate diagnostic techniques to detect them. Effective therapy is provided by accurate diagnosis, psychoeducation, and open therapeutic communication. Childhood

development was normal. However, at the age of 16, the patient had sexual intercourse with one of his male neighbours on 2–3 occasions. Since then, the patient has had frequent ideas of being gay, even though he has never had a sexual interaction. He was constantly unsure about his sexual orientation. He couldn't stop himself from thinking about the same-sex relationship. He was afraid that people of the same sex might find him appealing, so he avoided them. He didn't have any other psychological disorders. According to reports, gay obsessions have a lifetime frequency of roughly 11.9% among people receiving treatment for OCD. Furthermore, it appears that more males than females have sexual orientation obsessions. It is significant to recognise that people with sexual obsessions find their ideas unethical and do not desire to act on them. When considering same-sex partnerships, the person with HOCD finds it exceedingly unpleasant and finds it impossible to put the thoughts out of their head. Additionally, ritual/response prevention, imaginal exposure, vivo exposure, and mindfulness/acceptance strategies are being used. OCD, depression, and anxiety can all be treated with SSRIs (selective serotonin reuptake inhibitors)

Sexual obsessions are prevalent in people, cause significant distress when they have obsessive-compulsive disorder (OCD) and are frequently regarded as a danger to others. For this study, 383 children were taken as a sample. The results show that children with OCD and sexual obsessions are more depressed and violent, have magical thinking and religious obsessions, are afraid to speak certain words, repeat rituals, play superstitious games, engage in mental rituals, and have a greater urge to tell, ask, or talk to others. This study concludes that, even in very young children, sexual obsessions are widespread in paediatric OCD. Recommendations are that children suffering from sexual obsession be recognized and treated with CBT (Cruz et al., 2013).

There is a possibility that obsessive-compulsive disorder sufferers may find sexual obsessions to be deeply distressing, according to a study on sexual orientation obsessions in OCD. As a means of assessment, the YBOCS, or Yale-Brown Obsessive Compulsive Symptom Checklist, was applied. The finding revealed that there has, however, been little study on issues related to sexual orientation, such as persistent self-doubt, anxiety about transitioning towards homosexuality, or anxiety about what other people would think. The sample size was 409 adults. The study's conclusions suggest that people who have obsessions with their sexual orientation may be more impaired, devote greater amounts of time thinking and anxious,

experience more discomfort and humiliation, and spend more time worrying and ruminating (Williams & Farris, 2011).

The study by Abbey et al. (2007) aimed to investigate the romantic relationships of people with obsessive-compulsive disorder (OCD). There were 64 OCD sufferers among the participants. According to the findings, the degree of obsession was adversely connected with closeness, relationship satisfaction, and self-disclosure. In contrast, obsessive behaviours like washing and neutralising were found to be positively linked with a variety of relationship characteristics. The results showed that worries about contamination from sexual activity were strongly connected with the severity of OCD symptoms. The study found that sexuality is an important part of intimacy and that OCD is associated with sexual dysfunction. A future study should look at how some obsessive behaviours might improve relationship functioning in people with OCD.

There are distinct clinical correlations between hoarding behaviour. Conducted a collaborative genetics study using a sample of 358 women and 151 men with OCD. The findings revealed that hoarding is associated with violent, sexual, and religious obsessions as well as compulsions, tic disorders, and generalised anxiety problems that have been linked to male hoarding. However, in women, hoarding was linked to body dysmorphic disorder, anxiety about social situations, trauma-related stress disorder, and skin plucking, among other disorders. The results of the study imply that men and women with OCD may have different clinical correlates of hoarding behaviour (Samuels et al., 2008).

Sexual obsession and its clinical correlates in OCD-affected people because There is not a lot of information available on sexual obsession. The sample size consisted of 293 people who were all at least 18 years old. In participants with and without sexual obsessions, all factors were compared. Using the Yale-Brown Obsessive Compulsive Scale, the severity of the symptoms was evaluated. The findings of this study say that those with sexual obsessions report developing OCD at a younger age than those without these symptoms. The results revealed that OCD sufferers frequently have sexual obsessions and that these obsessions might be relevant to serious clinical signs and symptoms. Treatment studies are advised as a necessary element in determining if patients with violent, sexual, and religious obsessions require therapies that are particularly suited to them (Gant et al., 2006).

Gender-related clinical variations among OCD sufferers. There were 169 patients in total, ranging in age from 16 to 60. According to the study's findings, males and females were shown to exhibit sexual fixation and aggressiveness far more frequently than contamination obsessions. The result revealed that women had greater rates of obsessions and compulsions than men, whereas men had higher rates of social phobia and schizophrenia comorbidity. The outcome showed that OCD patients' clinical features and gender-related sociodemographic traits are present across different populations (Tukel et al., 2004).

The research attempts to raise awareness of the nature and content of sexual obsessions. The finding showed that sexual obsessions are one of the more prevalent signs of OCD. This provides information regarding other sexual ideas, such as those present in paraphilias, PTSD, and common sexual fantasies. Their structure, purpose, and impact on behaviour, however, differ substantially. The study concludes that failing to differentiate between these many kinds of sexual cognition might cause misunderstandings and iatrogenic treatments. For the treatment of sexual compulsions and OCD, exposure and response prevention (ERP) can be used with cognitive-behavioural therapy. It is suggested that before beginning ERP treatment, extra cognitive training is necessary (Gordon, 2002).

2.3 Studies Related to Religiosity and Religious Obsession in Obsessive-Compulsive Disorder

Religious obsession is a psychiatric illness characterised by excessive guilt or preoccupation over moral or religious matters. Obsessive moral or religious adherence often accompanies it, leading to stress and maladaptive behaviour (Miller, 2007). For a long time, people have been concerned about the link between religiosity, guilt, and OCD. Religious OCD symptoms include pathological doubt, religious themes, hyper-morality, sin-related anxiety, and excessive religious behaviour, which is also known as scrupulosity in psychiatric literature (Witzig & Alec Pollard, 2013). Strong religious beliefs may be viewed as a risk factor for OCD (Shafran et al., 1996; Rakesh et al., 2021). Given India's multi-religious population, it is essential to research the role of religion and guilt in the symptomatology and outcome of OCD, a disorder in which religious themes are frequently prominent (Rakesh et al., 2021). The researcher analysed literature on the state of religious obsession in patients suffering from OCD.

The purpose of the current study was to determine if LGBTQ+ people report higher levels of scrupulosity symptoms—that is, OCD symptoms based on religion as well as morality that are frequently categorised under the inappropriate thoughts dimension—than non-LGBTQ+ people. According to the findings, individuals who identified as LGBTQ+ had higher levels of "unacceptable thoughts" as well as symptoms of scrupulosity than participants who did not. The findings suggested that a relationship between religiosity and scrupulosity symptoms was moderated by fear of self, which also partially mediated the association between family acceptance of LGBTQ+ identity and scrupulosity symptoms. These findings imply that variables including identity, familial acceptance, and religion may be particularly significant for OCD symptoms in LGBTQ+ people and that these themes should be given more attention in studies and interventions about this population (Mangen, 2023).

A case of moderate obsessive-compulsive disorder (OCD) in a 28-year-old guy, which predominantly manifested as a pornographic addiction. The patient had auditory hallucinations, panic attacks, exam anxiety, and modest indications of compulsive and obsessive behaviours. However, the findings indicate that he actively engaged in porn consumption after the loss of his girlfriend's father, his separation from her, and the coronavirus illness 2019 (COVID-19). This quickly changed to religious pornographic content, which left him feeling guilty with fair insight. This ultimately led to his OCD becoming worse and him having to fix his cleaning obsession. According to the results, the patient reacted positively to follow-up appointments after beginning pharmacological and behavioural treatment. As diagnoses of such negative repercussions contribute to expanding the study of the range that may involve the psychological negative effects of pornographic use, it is recommended that improved reporting of forbidden thoughts be made in light of the particular presentation of this specific case (Shrivastava et al., 2022).

Sinha & Chakrabarti (2022) investigated the best way to treat prevalent obsessions by combining exposure and response prevention with thought-stopping. A 61-year-old retired school teacher provided the case study for this research. It was discovered that the patients suffered from religious obsessions, which are more prevalent in non-Western societies and are more likely to be linked to feelings of guilt, anxiety, and sadness. In an attempt to calm herself, she began praying more than usual, but as she was praying, she began to have visions and thoughts of burning places of worship, burning pictures of gods, idols, temples, and other sacred sites every time she went by. In addition, she experienced ideas and visions of having

sex with gods and a picture of lighting the home on fire while cooking. The results demonstrated that treatment benefits persist for two years. The success of this patient's therapy with a combination of thought-stopping and ERP implies that it may be beneficial to investigate the positive effects of this integrated treatment in well-controlled experiments with patients with the most prevalent obsessions

Rakesh et al. (2021) evaluate the effect of religiosity and guilt on the symptoms and outcomes of obsessive-compulsive disorder (OCD). The study also aimed to evaluate the pattern of symptoms in OCD patients and their relationship to religion and guilt, including fifty OCD patients aged 18 to 45 years. According to the findings higher levels of religion, spirituality, paranormal beliefs, and magical thinking frequently correlate with increased obsessive-compulsive behaviour. The results indicate that, at the outset, OCD severity was favourably associated with religion and guilt. Still, following a 6-month follow-up, it was negatively correlated with religiosity but positively correlated with guilt. The study suggested that religion and guilt had a substantial impact on OCD symptoms and outcomes.

Sharma, Sinha, et al. (2021) investigate the relationships between adult OCD symptom dimensions, emotional assessments, and obsessional beliefs. 50 adult OCD sufferers who do not use medications were evaluated with the assistance of the Obsessive Beliefs Questionnaire-44 and the Yale-Brown Obsessive-Compulsive Severity Scale. The findings showed that aggressive obsessions were linked to responsibility/threat assessment and perfectionism/certainty, two symptom aspects related to obsessive thoughts and contamination. Anger-related threat perception and dimensional symptom severities were linked to impairment. This correlation persisted even after considering the degree of obsessive beliefs and sadness. The results showed that the obsessive beliefs that cause OCD symptoms vary in their dimensions. Along with symptom intensity, emotional assessments have a major role in impairment. A suggestion is made: psychotherapy techniques targeting emotions need to be incorporated into OCD treatment plans.

Nagy et al. (2020) highlight the variables that influence suicidality in OCD patients and investigate the relationship between impulsivity and hostility and suicide attempts. SCID I, Y-BOCS, SPS, BIS-11, and SSI were used to examine 81 patients with OCD. The findings found that 27% had suicidal thoughts, 33% had tried suicide, and 37% had neither. Suicide ideation was related to high despair, severe OCD, and aggressive obsessions, whereas suicide attempts

were associated with prolonged untreated illness, cognitive impulsivity, severe OCD, and religious obsessions. The suggestion concluded that OCD patients require extensive suicide risk evaluations.

Scrupulosity can be observed frequently, yet it's an overlooked sign of obsessive-compulsive disorder, which is characterised by religious obsessions and compulsions. There is limited research on the relationship between scrupulosity and the acuteness of symptoms among individuals of different religions. The study used one-way ANOVA, regression analysis, and Pearson correlations on a sample of 180 adults. People who considered themselves to be Catholic had the highest degree of scrupulosity compared to those who claimed to be Protestant, Jewish, or agnostic. Globally, scrupulosity has a relationship with the severity of OCD symptoms. Conclusion this study requires additional evaluation tools and implications when performing evaluation and intervention, as well as taking religious beliefs into account while providing care (Buchholz et al., 2019).

Abdel Hamid et al. (2019) examined the connection between sexual and religious obsessions in bipolar illness patients and suicidal ideation. As samples, 90 people with bipolar I disorder were selected. The findings showed that 54.4% of the 90 patients in the total sample had bipolar disorder and sexual or religious obsessions and that they had significantly more suicidal attempts, more severe depression, and thoughts of suicide than people without such obsessions. The results indicate that patients with bipolar disorder are more likely to experience sexual and religious obsessions. Suicidal ideation may be more likely in people who have more severe depression and obsessive-related anxiety.

Olatunji et al. (2019) Studied the network of a few specific symptoms and belief patterns in OC (obsession and compulsive). The sample for this study consisted of 264 people. The 44-item Obsessional Beliefs Questionnaire and the revised version of the obsessive-compulsive inventory were used to assess the beliefs. The findings showed that OCD is characterised by a diverse range of symptoms, which might make diagnosis and categorization more challenging. Intrusive thoughts' negative evaluations (having intrusive thoughts indicates I'm out of control) were the network's most prominent symptoms. Some of the highest correlations between symptoms and intrusive thoughts and their unfavourable assessments were also seen. The main symptoms among individuals with a primary diagnosis of OCD that was anticipated were sadness and anxiety, but not the intensity of OCD symptoms. The result revealed that anxiety and depression, symptoms co-occur with negative evaluations of intrusive thoughts, making

them the most important symptoms in the OCD network. These symptoms should thus be given priority in OCD theory and treatment models.

Descriptive-analytic research on neuroticism and religiosity indicates that they are distal susceptibility variables for the OCD phenomena. To evaluate religious beliefs, the OCD Beliefs Questionnaire-44 was used. The findings revealed the need to investigate the functions of obsessive beliefs, thought-control techniques, and the guilt involved in the relationship between these variables and obsessive-compulsive symptoms (OCS), especially in Muslim communities where scrupulosity symptoms were found to be more prevalent. From 18 to 31 years old, 273 samples were collected. The results concluded that scrupulosity and other obsessive-compulsive symptoms are predicted by neuroticism and the level of religiosity. Also, these factors indicate compulsive thoughts that are favourably associated with self-punishment and guilt (Bilekli & Inozu, 2018).

Wu et al. (2018) examine OCD-affected young adults with and without religious symptoms in terms of clinical characteristics and treatment response, utilising a sample of 215 people. The findings revealed that paediatric OCD is a heterogeneous disorder with diverse symptom presentations that influence clinical features and treatment response. Religious OCD symptoms, such as worries about offending religious figures or artwork, were linked to increased overall OCD severity and worse treatment results. The results indicate that this subtype was more severe in aggressive, sexual, somatic, checking, symmetry, ordering, counting, and repeating symptoms, as well as having lower insight and more expressive family members. The study suggested that despite these variations, treatment outcomes were similar for teenagers with and without religious OCD symptoms.

The study examines how to strengthen our knowledge about feelings of shame in each obsessive-compulsive-related disorder. According to the study findings and conclusions, the most general forms of shame associated with OCRD include normal shame and embarrassment connected to having a mental illness; bodily humiliation as well as shame based on symptoms might be more specific in OCRDs. Obsessions with harm, sexual activity, or even blasphemy can lead to symptom-based embarrassment in OCD. Pulling and grabbing actions in a condition called trichotillomania, or peeling skin, may be linked to symptom-based shame. Hoarding disorder patients may experience embarrassment based on their symptoms, along with thoughts that they are not perfect because they live with clutter (Weingarden & Renshaw, 2015).

Psychological and clinical characteristics associated with compulsive sexual and religious behaviour were examined. A sample of 38 OCD sufferers who underwent cognitive therapy (CT) was gathered. The Yale-Brown Obsessive Compulsive Scale and Obsessive Beliefs Questionnaire-44 were used as tools. The findings indicate that the study looked at the connections between presumptive obsessional cognitive patterns, including beliefs regarding the significance and control over ideas and responsibility, obsessive-compulsive personality traits, schizotypal personality features, and sexual and religious obsessions. Particularly in the context of the possibility that having sexual and religious obsessions is associated with less successful treatment outcomes. The results revealed that the use of cognitive therapy is recommended since it may focus particularly on the pertinent belief domains connected to the patients' obsessive fears, which could bring about better results (Siev et al., 2011).

2.4 Studies Related to Clinical Correlates in Obsessive-Compulsive Disorder

Comorbid disorders are commonly mentioned by OCD patients. Perfectionism is a transdiagnostic process that contributes to the development and persistence of anxiety, obsessive-compulsive disorder (OCD), and depression (Lunn et al., 2023). Ruscio et al. (2010) discovered that anxiety and mood disorders were the most common mental illnesses among 2073 individuals diagnosed with lifelong OCD from the National Comorbidity Survey Replication, accounting for 90% of comorbidities. According to a comprehensive study and meta-analysis published in *Frontiers in Psychiatry* in 2021, 69% of almost 15,000 persons with OCD had comorbidity, with males being more prevalent than women (Sharma, Sharma et al., 2021). Relevant literature has been undertaken to better understand the major clinical correlates of obsessive-compulsive disorder in OCD patients.

Adi Friedman-Ezra et al. (2024) explored the link between loneliness and obsessive-compulsive disorder (OCD), emphasizing their demographic and clinical connections. The study utilized a cross-sectional approach, drawing on data from the Netherlands Obsessive-Compulsive Disorder Association (NOCDA) study, which included 363 adult participants diagnosed with OCD. The assessment covered loneliness severity, OCD symptoms, co-occurring conditions, and demographic characteristics. Results indicated that loneliness was highly prevalent, with 73.6% of participants experiencing elevated levels. Additionally, loneliness was closely tied to more severe depression and demographic factors such as age, gender, and education. Notably, depression explained the relationship between OCD severity and loneliness. The authors recommend future studies to develop interventions addressing

loneliness in OCD while accounting for its intricate relationship with depression and demographic variables.

The main goal of this family genetic study was to find out the familial risk of obsessive-compulsive disorder (OCD) and other common mental illnesses in first-degree relatives of people who were diagnosed with OCD as children. The sample included 130 young adults with OCD. The findings revealed that probands had much higher rates of anxiety, mood, disruptive behaviour, and tic disorders than controls, with siblings having rates comparable to probands. 26% of first-degree relatives had clinical OCD, 9% had chronic tics or Tourette's illness, and 21% fulfilled the ADHD criteria. Results revealed that rates of familial transmission of OCD and coexisting disorders were much greater in paediatric-onset probands than in relatives of those with adult-onset OCD. The suggestion emphasises the need for more studies into family transmission patterns and early therapies for paediatric-onset OCD to address higher comorbidities (Geller, Grossman, 2023).

Becker et al. (2023) examined death anxiety in OCD patients. The sample included 31 OCD sufferers and 31 healthy individuals. The findings demonstrated that death fear has long been associated with a role as a psychopathologically important element in the development of mental diseases such as obsessive-compulsive disorder (OCD). For example, people with washing compulsions indicate that their conduct is motivated by a fear of life-threatening infections. In contrast, people with control compulsions often report having to check things frequently out of fear that something dangerous or potentially fatal could happen to those around them. On the other hand, individuals with OCD showed higher levels of fear and negative attitudes towards death as compared to healthy participants. The results indicate that a significant correlation was found between anxiety and the existing religious obsessive thoughts in these individuals. Further investigation is recommended to explore the impact of death anxiety and unfavourable attitudes towards death in OCD patients.

Srivastava & Agarwal (2022) conducted a naturalistic investigation of obsessive-compulsive disorder (OCD) using a retrospective chart review of 125 OCD patients. The findings show that the mean age was 36 years, with an average sickness duration of 8.6 years and a follow-up duration of 45.5 months. The condition generally starts in the late 20s. Comorbidities were present in 41% of patients, with bipolar disorder (28%) and schizophrenia (13%). A family history of mental disease was discovered in roughly one-third of the patients. "Normal" or

"better" outcomes were reported in 41% of pure OCD patients, 19% of OCD with bipolar illness, and 5% with OCD and schizophrenia. The results revealed that patients visited clinics more frequently during severe disease stages and continued treatment with fewer visits when their condition stabilised. This concept suggests the significance of psychological support and correct diagnosis, as well as targeted pharmacological and psychological treatment, for effectively managing OCD and associated comorbidities.

The study conducted by Raza & Gracious (2022) investigated that Obsessive-compulsive symptoms in schizophrenia are frequently overlooked or ignored throughout the diagnosis process. Sexual obsession is frequent in people with schizophrenia. Identifying sexual issues early in therapy has significant implications for the most effective cross-disciplinary treatments and prognoses. A case of a Hispanic guy in his twenties who arrived with self-injurious conduct and increasing psychotic symptoms in the setting of a recent diagnosis of schizophrenia. This case clarifies the necessity of identifying the underlying cause of self-injurious behaviours, which in this young man was due to new-onset OCD manifesting as sexual obsession comorbid with schizophrenia. suggestions Olanzapine, paroxetine, and cognitive behavioural therapy (CBT) were used successfully.

Individuals with coexisting GAD and OCD differ from those with OCD without comorbid GAD in terms of their clinical conditions and sociodemographic traits. The findings revealed that a female would be more likely to start developing OCD at a younger age, and exhibit greater avoidant strategies, more self-harm and higher-level anxiety signs, and a higher prevalence of mood disorders as well as anxiety, there has been an increase in the level of severity of irritable, sexual/religious, and contamination-related OCD symptoms. 867 persons with OCD participated in the study and 291 people also had GAD. Participants' ages ranged from 18 to 65. The result confirmed that comorbid GAD was specifically linked to more avoidant strategies, higher anxiety intensity, panic disorder without bipolar mental illness, social anxiety, agoraphobia, simple phobia, and panic disorder. The study demonstrates that there is a need for a GAD diagnosis in OCD patients. According to the study's limitations and recommendations, future research should examine if this comorbidity affects the treatment of OCD (Sharma et al., 2021).

A total of 48 individuals with panic disorder were taken as a sample. According to the findings, 41.7% of panic disorder patients had either subclinical or clinical OCD, and around 60% of patients with panic disorder had at least one OCS. OSCs (obsessive-compulsive spectrum disorders) are common in PD and typically occur before they manifest. In 70.4% of the cases, OCS was more prevalent in women and occurred before the beginning of PD. The result revealed that people with panic disorder fear going crazy during panic episodes. Clinicians should make direct and frequent inquiries about them, especially in the case of checking compulsions and somatic, aggressive, and contamination obsessions. OCS has been shown to occur frequently before the onset of PD, and OCS research may help identify children at risk for PD. For the evaluation of patients with OCS, further research is required to look at the emergence of other comorbid illnesses, including panic disorder (Torres et al., 2019).

OCD sufferers frequently specify psychological or social stress as a cause of worsening their symptoms and often relate their development of disorders to tough circumstances in their lives or specific traumatic experiences. It is unknown if trauma or stress are separate sources of obsessive-compulsive disorder symptoms. Stress has been linked to major changes in limbic and corticostriatal circuits, according to an experimental study. The prefrontal cortex, dorsomedial striatum (caudate), and hippocampus may all experience neuronal loss as a result of stress. According to the findings, these neurobiological consequences are consistent with brain abnormalities associated with obsessive-compulsive disorder and may aid in balancing routines and focusing on goals. A strategy for examining the manner in which stress affects or triggers obsessive-compulsive disorder symptoms is provided by goal-directed learning and behaviour (Adams et al., 2018).

There may be a relationship between OCD and cannabis abuse, and it is a false notion that cannabis may be used as a coping technique to relieve anxiety and despair in OCD sufferers. The sample size was 430 (young adults). The results of the study demonstrated that cannabis consumption is associated with the development of obsessive-compulsive disorder. Individuals with OCD symptoms should avoid using cannabis since they are more sensitive to developing problematic usage and cannabis use disorder (Spradlin et al., 2017).

Ghassemzadeh et al. (2016) evaluated sexual function in OCD patients who had or did not have depressive symptoms. 56 volunteers with OCD between the ages of 18 and 50 were gathered as samples; 36 were female and 20 were male. Overall, in addition to having sexual dysfunction, 82% of women and 25% of men also reported having depression symptoms. The

findings demonstrated that comorbid despair is a common symptom of OCD, which is likely to contribute to the association between OCD and sexual dysfunction. The link between sexual dysfunction (the cycle of sexual response, including sexual desire, arousal, and pleasure), OCD, and depression may be related to psychopathology or medication side effects. The result showed that anxiety, depression, and dysfunctional sexual behaviour are all related and influenced by psychological elements such as guilt, shame, learned behaviours, interpersonal relationships, societal and cultural expectations, and gender roles. Suggestion: Nursing education has not given appropriate consideration to human sexuality; thus, regular training for professional nurses is advised in order to handle any sexual challenges that may arise during their daily patient care. Everyone in the community, not just nurses, should be educated on sexual health issues.

Piacentino et al. (2016) investigated the relationship between anger and other psychopathological characteristics with particular obsession subtypes in OCD patients. The study consisted of 57 OCD patients on their initial visit to a psychiatric outpatient clinic. The findings revealed that, despite the relevance of psychopathological features in OCD, their relationship with obsessive subtypes had not previously been studied. Results demonstrated that OCD patients with comorbid obsessive-compulsive personality disorder had greater degrees of obsessiveness and anger. There were significant relationships discovered between anger and aggression and various obsessions, as well as other aspects such as anxiety, melancholy, impulsivity, and somatic concern with specific obsession types. The study reveals that these psychopathological aspects are associated with distinct obsession subtypes in OCD patients.

Wisco et al. (2014) conducted a study on the impact of rumination and other cognitive emotion regulation mechanisms in relation to cognitive biases and depressive symptoms. The study included eighty-nine participants. The findings suggest that negative biased thinking significantly contributes to the onset and duration of depression, potentially increasing the risk through rumination, which involves repeatedly focusing on one's mood. The results indicate that rumination plays a significant role in the connection between cognitive biases and depressive symptoms. The study implies that interventions targeting rumination may help alleviate depression symptoms associated with negative biased thinking. Therapeutic interventions aimed at reducing rumination by interrupting and reframing harmful thoughts could be beneficial.

Gupta et al. (2014) assess the occurrence of suicidal thoughts and investigate the causes of suicidal ideations and self-harm attempts in patients with OCD. Using the DSM-IV OCD insight specifications, 130 patients with OCD were examined using the Yale-Brown Obsessive-Compulsive Scale as well as the Symptom Checklist. The findings of the 130 patients show that 60 (46.1%) had present SI and 81 (62.3%) had lifetime SI. According to SCID-CV assessments, 30 of the 60 individuals with present SI also reported depression. Depression was a lifelong comorbidity for more than half of the individuals with SI. There were ten patients with a history of unsuccessful attempts at suicide. Current suicidal ideation was linked to the feminine gender, co-occurring mental diseases, obsession with contaminating substances, and compulsions to clean and wash in individuals without current depression. The results indicate that SI is very widespread in OCD patients. While depression might indicate a risk factor for suicidal thoughts in patients with OCD, it isn't the only factor.

The cross-sectional investigation was done by (Torres et al., 2013) to identify the clinical characteristics of pure OCD in a large sample of 955 adults who were 18 years old or older. The finding is that relatively few studies have been done on non-comorbid or "pure" OCD based on specific clinical characteristics that have never been looked into, such as the extent of the symptoms (presence and severity), sensory phenomena, traumatic experiences, and level of insight. Various comorbidity patterns are important in OCD, even though this is a commonly accepted fact. According to the results of a study, pure OCD patients made up a small portion of this extensive sample and were distinguished by having more female partners, experiencing less extreme anxiety and depression feelings, having fewer suicidal ideas, and using psychotherapy less frequently as a type of therapy. It is advised that further study be done in this area.

Obsessive-compulsive disorder (OCD) is a long-lasting mental disorder that can impair everyday functioning. A systematic review of five databases was done for studies examining sleep in individuals with OCD. The findings revealed that several sleep problems were associated with depression. Some OCD patients, however, reported delayed sleep as well as a higher prevalence of delayed sleep phase disorder (DSPD). Significant OCD symptoms were consistently present due to increased sleep disruption. The result indicate that while sleep disturbance in patients with OCD hasn't been a big priority since now, according to the available research, treating sleep disruption holistically for OCD sufferers may ensure

treatment effectiveness, minimise relapse, and guard against the emergence of co-occurring mental diseases (Paterson et al., 2013).

D'Ambrosio et al. (2010) evaluate OCD patients for variations of social, economic, and health-related factors based on whether or not a person has a cyclothymic temperament. There were 167 patients in the study. The findings indicated that 90 people (53.9%) had a dominant emotional temperament. Cyclothymic emotional temperament was the most prevalent in the patient population with OCD (19.2%). People with OCD with CT may be more severe and complex than people without CT. Furthermore, those with OCD spectrum illnesses may be prone to bipolar disorder. A comprehensive examination of emotional temperament is required to diagnose OCD in the presence of such soft-bipolar comorbidity.

Anxiety disorders and despair that coexist with violent, sexual, religious, and physical obsessions are often linked to factor 1. Factor two (symmetry obsessions, repetition, numbers, and organising or arranging compulsions) and factor three (obsessions with cleanliness and contaminating things) are associated with bipolar disorder and panic disorder, respectively. Early-onset OCD is linked to factors I and II. The result revealed that OCD frequently co-occurs with other cognitive conditions, and there are patterns that are quite specific in terms of associations between high amount of severity of OCD symptoms the severity of OCD symptoms and co-occurring disorders, supporting the significance of the treatment of the OCD subtype, genetics, and additional investigations into this complex mental illness (Hasler et al., 2005).

Major depression with obsessive-compulsive disorder are the two comorbid conditions that are found most frequently, according to the study (OCD). 80 samples in total were interviewed, and 73 control subjects were evaluated. Since the majority of people have major depressive disorder that coexists with OCD, the study's main finding relates to the relationship between OCD and major depressive disorder. Significant depression, generalised anxiety disorder, and "OCI spectrum illnesses" are more prevalent in OCD, which is a hereditary disorder. Both OCD prototypes with and without RDD were compared with these. The result revealed significant OCD symptoms and a higher likelihood of having a family history of RDD (recurrent major depressive disorder). The comorbid group had higher rates of body dysmorphic disorder, separation anxiety disorder, and fear of social situations. OCD sufferers are more likely to develop anxiety disorders and depressive disorders at a young age. The

conclusion revealed that individuals with comorbid RDD (recurrent major depressive disorder) have higher levels of obsession with sexuality and religion (Hong et al., 2004).

2.5 Studies Related to Quality of Life Among Patients with Obsessive-Compulsive Disorder

Quality of life (QOL) refers to an individual's intellectual and emotional well-being, which is influenced by several elements such as happiness, job satisfaction, interpersonal connections, and sexual wellness (Żerdziński et al., 2022). Obsessive-compulsive disorder (OCD) is one of the most debilitating mental health illnesses, affecting both the patient's and carer's quality of life. This problem adds to the load on families, which can disrupt family relations and hamper the treatment of the disorder. Cognitive behavioural therapy (CBT) is a well-validated first-line treatment for OCD, in addition to medication. However, therapy outcomes vary across patients, with many enduring remaining symptoms and modest improvements in the quality of life of people suffering from OCD (Morgieue et al., 2016). Considerable studies have been explored to better understand how OCD sufferers' quality of life is impacted by their obsessive-compulsive condition.

Obsessive-compulsive disorder's course and clinical correlations, both with and without co-occurring personality disorders. Adults seeking treatment with OCD as their primary diagnosis comprised the participants (n = 263). The findings showed that it is unclear how comorbid personality disorders affect the course and outcome of OCD. Results indicate that people with comorbid personality disorders had higher rates of persistent depression and OCD. Individuals who have co-occurring personality disorders have higher levels of overall disability. In conclusion, it is suggested that individuals who have both OCD and comorbid PDs may need special consideration when designing and implementing their treatment plans since they exhibit a higher level of total impairment (Belli et al., 2024).

In a hospital-based, longitudinal, descriptive study of 100 patients with obsessive-compulsive disorder, there is no Indian research that has assessed the influence of stigma, degree of severity, and insight on the quality of life in obsessive-compulsive disorder. According to the findings, overall quality of life and the degree of psychological illness were significantly negatively correlated. Poorer insight on the Brown Assessment of Beliefs Scale (BABS) was connected with poorer overall health, and higher intensity of obsessions considerably increased stigma. According to the results, the stigma and severity of OCD have a considerable

detrimental influence on the quality of life. Stigma reduction and adequate severity control should be basic components of OCD treatment (Garg et al., 2023).

The purpose of the study was to look at the sensation of happiness and other characteristics of quality of life (QOL) in individuals with obsessive-compulsive disorder. Seventy-five people with OCD were included. The findings demonstrated that OCD is a persistent mental condition characterised by obsessions and compulsions that interfere with normal psychosocial functioning. Treatment is sometimes inadequate and delayed, even with an early onset. The results revealed a negative relationship between happiness and OCD severity, obsessive-compulsive personality characteristics, and comorbid mental illnesses such as aggressiveness, impulsivity, depression, and sexual dysfunctions. Patients with OCD experienced increased degrees of loneliness and a considerable delay in therapy. A further suggestion is that examining quality of life components should be part of OCD diagnosis and treatment (Żerdziński et al., 2022).

Singh et al. (2022) evaluated the OCD sufferers' quality of life and marital adjustment. The findings revealed that 2.3% of the general population suffers from obsessive-compulsive disorder (OCD), a long-lasting condition. Since a marriage includes a man and a woman becoming husband and wife, it is the backbone of family life. The term "quality of life" describes a person's feelings about their own social, emotional, and physical health. Results show that OCD has a direct impact on couples and causes a great deal of frustration and unhappiness in the marriage. It is also linked to the illness's stigma and social standing, which lowers couples' quality of life even more. According to the study, it is essential to take emotional and adjustment dissatisfaction into account at the time of diagnosis since it is significantly greater in couples among people with obsessive-compulsive disorder than in normal couples.

Raje et al. (2020) examine the social support, coping, and interpersonal behaviour of people with OCD. The findings revealed that a disabling condition is an obsessive-compulsive disorder marked by intrusive thoughts that are invasive and repeatedly stressful in nature, which results in repeating compulsive mental and physical behaviours. 30 OCD sufferers and 30 healthy controls made up the sample. As tools: the Yale-Brown Obsessive-Compulsive Scale, the Coping Style Questionnaire, and the Social Support Questionnaire. The results indicated that, in comparison to healthy controls, poor coping abilities, a lack of social support, and a low perception of social support were all present in OCD patients. The present study's

potential conclusion that interpersonal behaviour is related to patient social interaction necessitates further research into social cognition, interpersonal effectiveness therapy, and resilience training in future interventions.

Obsessive-compulsive disorder (OCD) is a chronic mental health problem that is recognised as one of the leading causes of disability and poor quality of life. According to the data, 10% of female OCD patients experienced anorgasmia and 22% had sexual arousal phase issues, whereas 25% of male patients had reduced sexual arousal. The findings show that sexuality is one of the aspects of quality of life and well-being, but it is an issue that medical professionals working with OCD undervalue. According to the conclusion, sexuality-focused therapy techniques should be adopted in this clinical group to enhance OCD patients' quality of life (Pozza et al., 2020).

Stein et al. (2019) investigated that patients with OCD have a significantly lower quality of life than healthy controls in various aspects such as social interactions, family life, and work compared to individuals without the disorder. Furthermore, relatives and caregivers of OCD patients also have a lower quality of life compared to healthy individuals. According to the findings and recommendations, effective therapies for the available treatments for OCD include serotonin reuptake inhibitors, cognitive behavioural therapy, and neurosurgery, particularly for patients with severe symptoms. Awareness and treatment results for OCD can probably be improved by bringing together translational neuroscience and global mental health methods.

Obsessive-compulsive disorder (OCD) has an impact on sufferers' lives and their relationships. A total of 353 adult patients with present OCD were used as a sample. The findings suggested that relationship happiness and quality of life were both unsatisfactory. Not having paid job opportunities and more severe mixed symptoms of anxiety and depression were related to worse QoL. Worse relationship satisfaction has been related to fewer checking symptoms, more severe co-occurring depression signs and symptoms, and a belief that relationships lacked emotional support or were dissatisfied. The results and suggestions included that therapy should focus on how partners regard one another and co-morbid disorders that are hindering the patient's ability to work in order to improve quality of life and relationship satisfaction. (Remmerswaal et al., 2016).

Kumar et al. (2014) focus on investigating the association between quality of life and disability levels in obsessive-compulsive disorder (OCD) and dysthymic disorder (DD). The hospital-based study collected 30 samples. The findings suggest that mildly disabled OCD patients had a considerably better quality of life than moderately disabled individuals. The result demonstrated that light disability has marginally better QOL than moderate impairment in OCD, whereas this difference is much less in DD. This means that among people with a minor disability, the physical domain of the QOL score in dysthymic disorder is substantially poorer. Further indications indicate that there is a need to investigate the function of the physical component of QOL with impairment in DD.

Obsessive-compulsive disorder (OCD) has serious consequences and a high illness burden, according to the findings. Enhancing quality of life is becoming a more crucial part of healthcare, particularly in the area of mental health. The result revealed that OCD patients' quality of life (QOL) is considerably lower than that of the general population and patients with other mental and medical diseases. Similarly, comorbid illnesses tend to significantly impact QOL in OCD, which should be considered while creating a treatment strategy. Additionally, it has been investigated that both individual and group psychotherapy and medication can enhance OCD patients' quality of life. In addition to symptom reduction, treatment professionals should work to ensure that patients have achieved their everyday functioning and enjoyment (Macy et al., 2013).

2.6 Studies Related to the Treatment of Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a neuropsychiatric condition that affects generally 1–3% of the population (Pallanti et al. 2011). The operational criteria of therapeutic response, partial response, and remission in obsessive-compulsive disorder (OCD) are commonly employed in clinical studies and daily practice. However, the clinimetric sensitivity of these categories, or whether they identify patients who experience important changes in their daily lives, has yet to be investigated (Mataix-Cols et al., 2022). The existence of comorbid disorders is frequently associated with non-response to therapy, which is an essential consideration in assessing comorbidity (Pallanti et al., 2011.) The researcher reviewed the literature on the current status of treatment and the approach used for OCD patients.

Toprak (2024) carried out a case study on three individuals with religious OCD aged 35 to 38 to assess the efficacy of Rethinking Cognitive Psycho-Education (4T Model) in psychotherapy.

According to the findings, some obsessions and compulsions, such as hoarding and religious obsessions, were less receptive to ERP, resulting in higher dropout rates. The findings suggested that new-wave cognitive techniques, such as mindfulness-based treatments, possessed promise. Participants who had previously struggled with CBT reacted more positively to the 4T model interventions. The study concluded that the 4T model, which is religiously sensitive, had a substantial influence on differentiating beliefs and values from other cognitive processes in the treatment of religious OCD.

Dehaghi et al. (2024) sought to create and assess an integrated treatment protocol that combined religious elements with Acceptance and Commitment Therapy (ACT) to address obsessive-compulsive disorder (OCD), dysfunctional beliefs, guilt, scrupulosity, and thought control in a Muslim population in Tehran, Iran. The study employed an exploratory mixed-methods approach, incorporating document analysis to adapt ACT with religious content, which experts subsequently validated. A semi-experimental pretest-posttest control-group design was conducted, involving 25 individual sessions of the adapted ACT and 8 sessions of conventional ACT, with a follow-up period of three months. Participants were chosen based on defined diagnostic and demographic criteria. The findings showed that the religion-adapted ACT significantly reduced OCD symptoms and dysfunctional religious beliefs more effectively than the conventional ACT. The results highlight the added value of religious components in improving ACT's efficacy for addressing purity/impurity obsessions in this population. Future studies are recommended to evaluate the broader applicability of this approach across different cultural and religious settings.

Huang et al. (2023) conducted a review to investigate the concept of insight in OCD and its multifaceted role in clinical characteristics, neuroimaging mechanisms, and treatment for OCD. The findings indicate that Obsessive-compulsive disorder (OCD) is a chronic disabling disease with often unsatisfactory therapeutic outcomes. Studies have demonstrated that insight can impact therapeutic efficacy and prognosis, underscoring its importance in the treatment of mental disorders, including OCD. The result revealed that In recent years, there has been a growing interest in understanding the influence of insight on mental disorders, leading to advancements in related research. However, a review of the study still shows that there is a dearth of comprehensive reviews on the topic of insight in OCD.

Obsessive-compulsive disorder (OCD) is a neuropsychiatric illness that affects men and women equally but develops in a sexually dimorphic way. According to the findings, reproductive cycle events might impact the intensity of OCD symptoms in women, indicating that ovarian hormones or their interactions with different neurotransmitter systems may play a role in OCD pathogenesis. Their interactions with various neurotransmitter systems may contribute to the pathophysiology of OCD. Clinical research and animal models have demonstrated the importance of the serotonergic system in the neuropsychology and treatment of OCD. Females who received fear extinction training throughout the metestrus and diestrus stages of the estrous cycle were shown to be more susceptible to meta-chlorophenyl piperazine (mCPP)-induced impairments. According to the results, meta-chlorophenyl piperazine (mCPP) can cause OCD-like symptoms such as increased self-training and reduced fear extinction (Reimer et al., 2018).

The core principles and techniques of Acceptance and Commitment Therapy (ACT) and its effectiveness in minimising stigma while improving engagement in mental health treatment. By conducting a thorough review of existing literature, the research assessed ACT's ability to address both social and self-stigma associated with mental health issues and psychological disabilities. The findings highlighted ACT as a validated therapeutic model within the third wave of cognitive therapies, showing significant effectiveness in working with stigmatised groups. Through fostering acceptance and enhancing psychological flexibility, ACT helps to reduce stigma, thereby increasing participation in therapy and improving treatment outcomes. Future research should focus on exploring ACT's use in diverse contexts and assessing its long-term impact on reducing stigma and expanding access to mental health care (Larmar et al., 2014).

Steketee et al. (2011) evaluate the factors that might indicate how well patients who get a complete cognitive treatment (CT) for obsessive-compulsive disorder (OCD) would do. A total of 39 people who were at least 18 were sampled. The finding showed that a 22-session course of treatment includes both conventional CT techniques and tailored OCD coping mechanisms for subtypes including sexual, religious, and other obsessions. Individuals who thought they had more severe OCD at the beginning of the study stayed in treatment, although more severe symptoms were only slightly related to worse outcomes for those who finished therapy. Comorbid diagnoses (mostly significant depression and anxiety disorders). The result revealed that people who first exhibit more severe symptoms may require a longer course of therapy.

Cognitive treatment may benefit OCD symptoms as well as associated depression and anxiety illnesses and related underlying core beliefs.

Exposure and ritual prevention can be used to treat obsessive-compulsive disorder patients with sexual orientation obsessions. A study using exposure and ritual prevention therapy is conducted on a 51-year-old heterosexual male with obsessive-compulsive disorder (OCD) who has obsessions related to his sexual orientation. According to the findings, symptoms of OCD included concern over the chance of turning gay, a need for mental comfort, and avoiding other people, especially males. These symptoms led to depressive symptoms and marital stress. Furthermore, the study found that sexual obsessions are ego-dystonic, manifesting as unpleasant intrusive thoughts. The results revealed that E/R therapy is still successful for people with OCD who have sexual obsessions. Mood, quality of life, and social adjustment all showed signs of improvement. The limitations of this study suggest that people who experience obsessions with a sexual orientation frequently have this type of fixation misdiagnosed or undiagnosed. The suggestion concluded that when someone with OCD seeks therapy, questions concerning sexual content should be asked like questions about other obsessions. Exposure therapy must become more widely known so that people suffering from sexual obsession can be treated just as effectively as those suffering from other types of OCD (Williams et al., 2011).

2.7 Conclusion from the Literature Review

Obsessive-Compulsive Disorder (OCD) is a chronic neuropsychiatric condition characterised by intrusive obsessions and compulsions, affecting 1-3% of the population (Cervin, 2023). It often emerges in adolescence or early adulthood and can cause significant impairment if left untreated. While OCD is categorised under the DSM-5 and ICD-11, it is frequently misdiagnosed or undertreated (Stein et al., 2019). Sociodemographic factors, such as education, IQ, and wealth, play a role in its prevalence and severity, with higher education and IQ potentially increasing risk, while wealth may serve as a protective factor (Baranova et al., 2024).

Sexual and religious obsessions are common in OCD. Sexual obsessions affect 16.8% to 30% of patients and often involve fears related to sexual orientation, inappropriate sexual acts, or aggression (Kuty-Pachecka, 2021; Rasmussen & Tsuang, 1986). These obsessions are linked to childhood trauma, increased anxiety, depression, and relationship dysfunction (Boger et al.,

2020; Steinberg et al., 2016). Misdiagnosis with paraphilias is a concern, emphasizing the need for accurate clinical assessment (Vella-Zarb et al., 2017). Cognitive-Behavioral Therapy (CBT) and selective serotonin reuptake inhibitors (SSRIs) are primary treatment approaches (Koolwal et al., 2022).

Religious obsessions, including excessive guilt and scrupulosity, are prevalent in OCD and may be influenced by strong religious beliefs (Shafran et al., 1996; Rakesh et al., 2021). Scrupulosity manifests as pathological doubt, moral concerns, and excessive religious rituals, contributing to distress (Witzig & Pollard, 2013). Studies highlight that religious beliefs, particularly in non-western societies, are associated with greater OCD severity (Bilekli & Inozu, 2018). Guilt, rather than religiosity alone, appears to be a significant emotional factor (Rakesh et al., 2021). Treatment includes thought-stopping techniques and exposure-response prevention (ERP) (Sinha & Chakrabarti, 2022).

Comorbidities in OCD are common, with anxiety, mood disorders, depression, schizophrenia, and panic disorder frequently co-occurring (Sharma et al., 2021; Raza & Gracious, 2022). Genetic predisposition plays a role, and familial transmission is evident in pediatric-onset OCD cases (Geller & Grossman, 2023). OCD is also linked to death anxiety, sexual dysfunction, and sleep disturbances, further complicating treatment (Becker et al., 2023; Pozza et al., 2020; Paterson et al., 2013).

Quality of life (QoL) in individuals with OCD is significantly reduced due to symptom severity, comorbidities, and social stigma (Belli et al., 2024; Garg et al., 2023). Poor insight, relationship difficulties, and marital dissatisfaction further impact well-being (Singh et al., 2022). Despite treatment, many patients experience limited improvements in QoL (Morgieva et al., 2016). Holistic, personalized treatment approaches addressing both psychological and social aspects are essential for better patient outcomes (Żerdziński et al., 2022).

Further research is needed to explore the neurobiological, clinical, and treatment-related aspects of OCD, particularly in relation to sexual and religious obsessions, which remain understudied despite their substantial impact on QoL (Gordon, 2002).

This review examines various treatment approaches for obsessive-compulsive disorder (OCD), highlighting key studies on cognitive, behavioral, and pharmacological interventions. Research underscores the role of cognitive-behavioral therapy (CBT), particularly exposure and response prevention (ERP), though religious and sexual obsessions pose treatment challenges (Toprak, 2024; Williams et al., 2011). New-wave therapies like Acceptance and Commitment Therapy (ACT) and the 4T Model show promise, particularly when culturally adapted (Dehaghi et al., 2024; Larmar et al., 2014). Insight, comorbidities, and neurobiological factors significantly

influence treatment outcomes (Mataix-Cols et al., 2022; Reimer et al., 2018). Future studies should focus on longitudinal efficacy, cultural adaptations, and stigma reduction (Steketee et al., 2011; Pallanti et al., 2011).

2.8 Research Gap

Obsessive–compulsive disorder (OCD) is often wrongly viewed as a problem mainly involving contamination and cleaning. Consequently, other significant symptoms, particularly sexual and religious obsessions, are often neglected (Miller, 2024). This misunderstanding is even more common in India, where awareness about sexual obsessions is very low. Many people hesitate to talk about sexual concerns due to cultural stigma, and even trained mental health professionals may not have enough knowledge in this area (Jaisoorya et al., 2017; Shabnam & Mishra, 2020). As a result, these symptoms remain under-recognised and under-discussed.

Research from other countries shows that sexual obsessions are actually quite common in OCD and can cause severe distress and impairment (Grant et al., 2006). Yet, despite sexuality being an important part of human life, very few studies have explored sexual themes in OCD in depth (Koolwal et al., 2022). Past findings also indicate that sexual and aggressive obsessions may occur even more frequently than contamination obsessions (Tükel et al., 2004). Specific concerns—such as obsessions about sexual orientation, fear of “becoming” homosexual, doubts about one’s identity, and fear of being judged—have been especially neglected in research, even though these issues cause significant rumination, shame, and daily impairment (Williams & Farris, 2011). OCD also commonly occurs along with anxiety and depression. Sexual and religious obsessions are often seen with these comorbid conditions (Hasler et al., 2005). However, studies that bring together sexual and religious obsessions, clinical factors like anxiety and depression, and their impact on quality of life—particularly among young adults—are extremely limited.

Another major concern is stigma within the mental health field. Evidence shows that clinicians may feel uncomfortable treating patients with sexual obsessions and may even have negative expectations about their treatment outcomes (Steinberg et al., 2016). This leads to underreporting, inadequate clinical training, and limited research on these sensitive forms of OCD.

Overall, there is a clear lack of comprehensive, culturally informed, and clinically integrated research on sexual and religious obsessions in OCD within the Indian context. Very few studies have examined how these obsessions relate to anxiety, depression, and quality of life.

Therefore, a systematic investigation is urgently needed to better understand these symptoms, reduce stigma, strengthen clinical training, and improve care for individuals experiencing sexual and religious obsessions in OCD.

2.9 The Rationale of the Study

Obsessive–compulsive disorder (OCD) involves several symptom dimensions, among which sexual and religious obsessions are especially distressing and disruptive. However, in India these symptoms remain poorly understood and rarely discussed because of cultural stigma, lack of awareness, and discomfort in talking about sexuality or religious guilt with family members or mental health professionals (Rakesh et al., 2021; Shabnam & Mishra, 2020). As a result, many individuals do not receive timely diagnosis or appropriate treatment, which negatively affects their overall quality of life. This makes it important to study the prevalence and clinical correlates of sexual and religious obsessions in the Indian context.

Although this research focuses on religious obsessions, the term “religiosity” is intentionally included in the title. This is because religious obsessions often arise from deeper psychological and cultural factors related to a person’s beliefs, values, moral rules, and religious practices— together known as religiosity (Abramowitz et al., 2004; Sica et al., 2002). Scholars such as Greenberg and Witztum (1987) describe scrupulosity, a form of OCD involving excessive religious or moral fear, as a distorted or extreme expression of religiosity. Previous studies also show that rigid, fear-focused, or guilt-driven forms of religiosity can increase the risk and severity of religious obsessions (Abramowitz et al., 2004; Greenberg et al., 1987; Sica et al., 2002; Yörmaz et al., 2009).

In societies where religion is deeply embedded in daily life—such as many parts of Asia, including India—religiosity strongly shapes how individuals experience and interpret their obsessive-compulsive symptoms. Therefore, understanding religious obsessions requires examining them within their cultural and psychological environment. Using the term “religiosity” in the title provides a broader and more accurate representation of this connection. Overall, this study is important because it addresses a neglected but clinically significant area of OCD. It aims to generate culturally relevant knowledge, enhance awareness among clinicians, and support the development of sensitive and effective interventions for people experiencing sexual and religious obsessions in India.

CHAPTER- III
RESEARCH
METHODOLOGY

CHAPTER- III

RESEARCH METHODOLOGY

Research methodology is the core of any research work, guiding how research studies are conducted. It provides information about the procedures usually used by researchers to examine a research problem. Kothari (2004) describes research techniques as a way to explain the research challenge analytically. This chapter's goals include formulating a technique to address the research objectives and providing an overview of the overall research strategy, research design, sample description, research instruments, validity and reliability associated with these instruments, statistical techniques, and ethical considerations for the study.

3.1 Research Design

The current study follows a cross-sectional research design. A deductive approach is employed, progressing from general theories to specific hypotheses. Both primary and secondary data are utilised to support the findings, with data collected through standardised psychological instruments (questionnaires).

3.2 Sampling Design and Sample Size

The present study employed a purposive sampling method, a non-probability sampling technique. A total of 100 young adults (aged 18 to 40 years) diagnosed with Obsessive-Compulsive Disorder (OCD) were selected based on hospital records confirming their diagnosis according to DSM-5 or ICD-10 criteria (Garg et al., 2023). To facilitate rapport-building, interviews were conducted. Participants were recruited from Ashoka Neuro Psychiatric Hospital & Addiction Centre in Jalandhar, Punjab, which serves a large and diverse patient population from various socio-demographic backgrounds.

3.2.1 Sample Size Justification

A sample size of 100 participants is justified for this study, considering the low prevalence rates of OCD in India (0.6%-0.8%; Reddy et al., 2010; Jaisoorya et al., 2017). A power analysis, based on a 95% confidence level, 80% power, and a medium effect size,

recommended a minimum sample size of 87 participants (Cherian et al., 2014). Using the formula $n = (Z_{\alpha/2} + Z_{\beta})^2 / d^2$, where $Z_{\alpha/2} = 1.96$, $Z_{\beta} = 0.84$, and $d = 0.3$, a sample size of 100 was chosen to enhance statistical power and account for data loss. This ensures adequate representation of OCD subtypes, including sexual and religious obsessions. Similar studies support this choice, such as Devi et al. (2023) with 103 OCD patients and Garg et al. (2023) with 100 patients. Additionally, Schwarzkopf and Huang (2023) highlight the feasibility of small sample sizes in healthcare research, making this selection both statistically sound and practical.

Focusing on young adults aged 18 to 40 with OCD is justified due to its prevalence and impact. A study in Kerala, India, found a 3.3% OCD prevalence, with taboo thoughts and mental rituals as common symptoms (Jaisoorya et al., 2017). Erikson's theory (1968) identifies this stage as intimacy versus isolation, where OCD disrupts relationships and careers. Studying this group aids in understanding OCD's clinical and psychosocial implications.

3.2.2 Criteria of Sample Selection

Inclusion Criteria:

- People aged 18–40 years.
- Primary diagnosis of OCD (DSM-5 or ICD-10).
- Patients from the psychiatric OPD and IPD.
- Both male and female participants.
- Minimum education level of upper primary.
- Able to be interviewed in person with the help of a Mini-Mental State Examination. (MMSE).

Exclusion Criteria:

- Individuals below 18 years.
- Participants with lower educational levels or illiterate individuals.
- Presence of organic mental illness.
- Inability to understand and provide informed consent.

3.3 Measure

The following research measures were used for the collection of data.

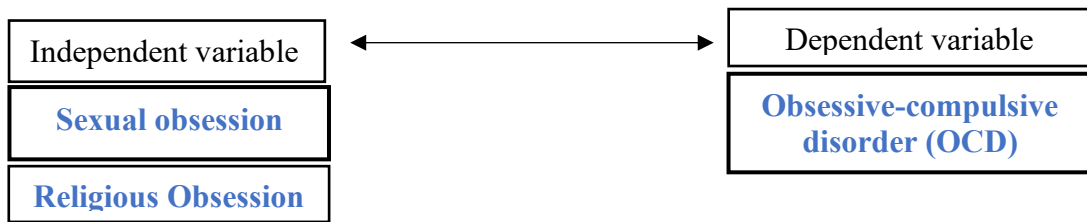
3.3.1 Variables

Table 3.1 *The Demographic variables for the research work*

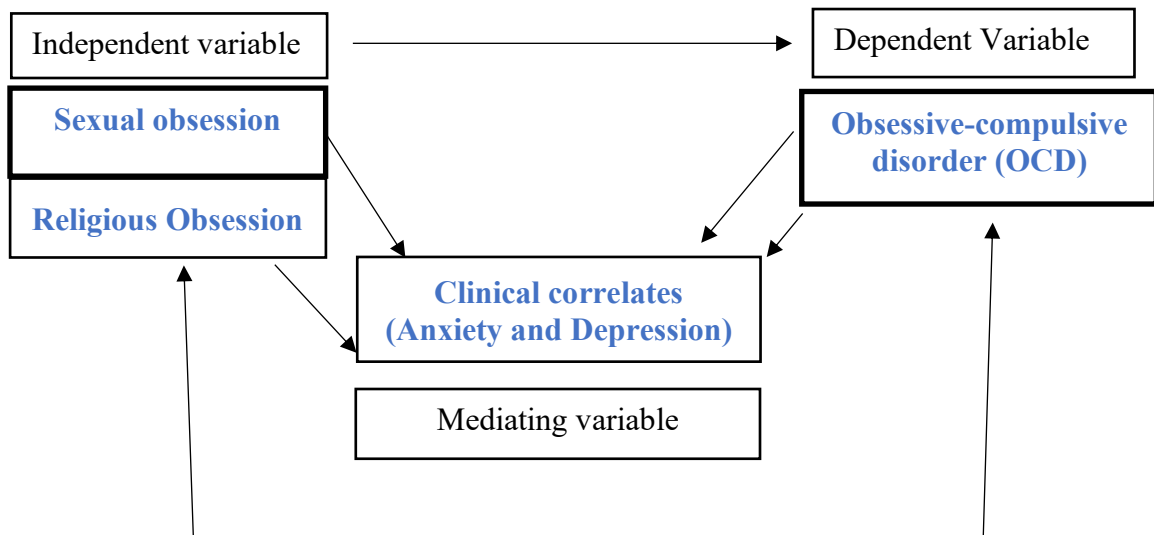
S. No	Variable	Category	Sub Category
01	Demographic variables	Gender	Male
			Female
		Age	18-40 Years
		Education	Secondary
			Tertiary
		Marital Status	Married
			Unmarried
		Settings	Rural areas
			Urban areas
		Family type	Nuclear Family
Joint Family			
OCD diagnosed from	Month/Year		
Taking any psychiatric drug	yes		
	No		
02	Independent variable		Sexual obsession
03	Dependent variable		Religious obsession
			Obsessive-compulsive disorder (OCD)
04	Mediator variable		Clinical correlates
05	Moderator variables		Quality of life

Figure 3.1 Variable explanation

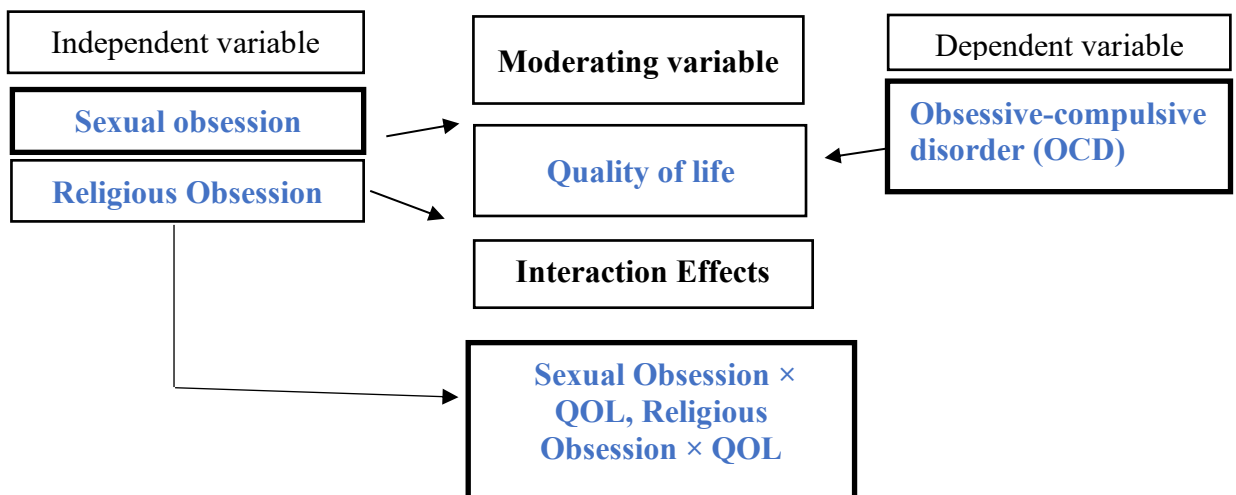
(A) Direct Relationship



(B) Mediating Effect



(C) Moderating Effect



3.3.2 The Yale-Brown Obsession-Compulsive Disorder Scale (Modi, 2016; Raje et al., 2020): The Yale-Brown Obsession-Compulsive Disorder Scale (YBOCS), established by Goodman et al. (1989), is a 10-item scale that is valid and reliable for use by clinicians in assessing the severity of obsessions and compulsions. More severe symptoms are indicated by higher YBOCS scores, which range from 0 (no symptoms) to 4 (intense symptoms), and total scores range from 0 to 40. The questions ranging from 1 to 5 are used to assess obsessions, while the questions ranging from 6 to 10 are used to assess compulsions. The scale contains questions regarding how much time the patient spends obsessing, how much suffering or impairment they encounter, and how much resistance and control they have over these thoughts. Compulsions are subjected to the same kinds of enquiries, such as time spent, interference, etc. The outcomes can be interpreted depending on the overall score (Raj, 2014). The YBOCS Symptom Checklist (YBOCS-SC) was given by raters before the YBOCS to collect data on particular present symptoms. This explains the various types of obsessions that can occur with OCD, including aggressive obsession, contamination obsession, sexual obsession, hoarding obsession, religious obsessions, obsessions with the need for symmetry or exactness, miscellaneous obsessions, somatic obsessions, cleaning/washing compulsions, repeating rituals, counting compulsions, ordering/arranging compulsions, hoarding/collecting compulsions, and miscellaneous compulsions. Cronbach's alpha value is 0.96, and Pearson's r value is 0.94 (Castro-Rodrigues et al., 2018). The scale has a validity of 0.89 and a reliability of 0.98.

3.3.3 Hospital Anxiety and Depression Scale (Kumari et al., 2020; Rishi et al., 2017): This self-administered rating scale was developed by Zigmond and Snaith (1997) and assesses the presence and severity of anxiety and depression. It measures distress on two subscales, the anxiety and depression subscales, both containing seven items. All 14 items are rated on a 4-point Likert scale coded from 0 to 3. A score of "0" in any item denotes lower psychological distress, while "3" denotes higher distress. The internal consistency of both the anxiety (=0.80) and depression (=0.76) subscales is high. Cronbach's alpha of the HADS-Anxiety subscale ranges from 0.68 to 0.93, and for the Depression subscale, it is 0.67 to 0.90.

3.3.4 WHO Quality of Life-BREF (Raj, 2014; Saxena et al., 1998): The WHOQOL Group created the WHO quality of life scale. The WHOOL was founded in 1997. There are four domains in total: physical health, psychological health, social health, and the environment. There are 26 total items with scores ranging from 1 to 5, and the negative phases Q3, Q4, and

Q26 all have reverse scoring. To calculate the score, the domain will be used. This questionnaire asks you to describe your feelings regarding your quality of life, health, and other elements of your life. Internal consistency (Cronbach's alpha) The coefficients of this scale range between 0.62 and 0.86, and discriminant validity is good.

3.4 Procedure

3.4.1 Procedure and administration of the research instruments

This study encompasses a cohort of 100 patients diagnosed with obsessive-compulsive disorder (OCD). After obtaining consent from the Ashoka Neuro Psychiatric Hospital & Addiction Centre in Jalandhar (Punjab) for data collection on OCD patients, we aimed to examine the presence of sexual and religious obsessions in OCD sufferers. Subsequently, we explored whether these types of obsessions are linked to clinical correlates such as anxiety and depression and assessed their impact on the patient's overall quality of life.

3.4.2 Screening Data from OCD Patients

For the present study, we included patients who visited the psychiatric outpatient department (OPD) and inpatient department (IPD) at Ashoka Neuro Psychiatric Hospital & Addiction Centre in Jalandhar (Punjab). Approval was obtained from the Institutional Ethics Committee of Ashoka Neuro Psychiatric Hospital and Lovely Professional University before approaching any patients. Before data collection, participants were informed of the study's objectives and given additional instructions. Only those who agreed to participate were included in the study. To select individuals who had received a diagnosis of OCD from a psychiatrist, we applied specific inclusion and exclusion criteria. Before administering surveys, we established rapport with the patients and provided a detailed explanation of our data collection goals. Participants were assured that their data would be kept confidential and used only for the study, and they were informed that they could withdraw from the process at any time. The study utilised the Yale-Brown Obsessive-Compulsive Disorder Scale (Y-BOCS), the Y-BOCS Symptom Checklist, the Hospital Anxiety and Depression Scale (HADS), and the WHO Quality of Life-BREF (WHOQOL-BREF) for evaluation. Each participant required 12 to 15 minutes to complete each questionnaire. As explained in Figure 3.2,

The Procedure For Screening The Sample

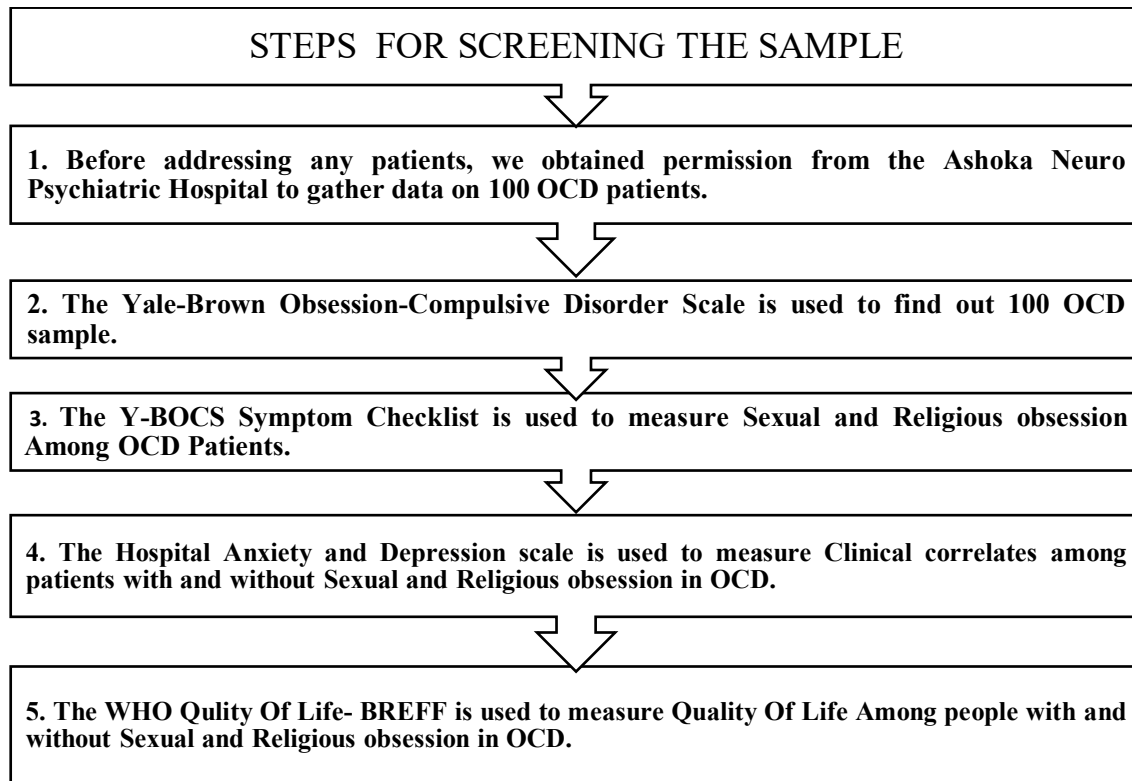


Figure 3.2 The Procedure for screening the sample

The chart outlines a five-step process for screening a sample of patients with Obsessive-Compulsive Disorder (OCD).

1. The first step involves obtaining ethical clearance and permission from the Ashoka Neuro Psychiatric Hospital to access data on 100 patients diagnosed with OCD.
2. In the second step, the Yale-Brown Obsession-Compulsive Disorder Scale (Y-BOCS) is employed to identify and confirm OCD symptoms in these patients.
3. Step three involves the use of the Y-BOCS Symptom Checklist to assess the presence and extent of sexual and religious obsessions in the patients identified as having OCD.
4. In the fourth step, the Hospital Anxiety and Depression Scale (HADS) is used to evaluate the clinical correlates, specifically anxiety and depression, in patients with and without sexual and religious obsessions.
5. Finally, step five uses the World Health Organisation Quality of Life (WHOQOL-BREF) instrument to measure the quality of life among OCD patients, comparing those with sexual and religious obsessions to those without these specific obsessions.

This structured approach ensures comprehensive data collection on both clinical symptoms and quality of life in OCD patients.

3.5 Ethical Consideration

We conducted the study exclusively with adult participants, adhering to the following ethical considerations:

1. Ethical approval for the research was obtained from the Institutional Ethical Committee (IEC) of Lovely Professional University, Punjab, on September 12, 2024, under reference number LPU/IEC-LPU/2024/3/10.
2. Participants were informed that the study was being conducted solely for research purposes.
3. Informed consent was obtained from all participants before they completed the questionnaires.
4. Participation was entirely voluntary, and no individual was obligated to take part in the study, even if they met the inclusion criteria.
5. Confidentiality was strictly maintained, ensuring that participants' responses remained anonymous and their identities were not disclosed in any way.
6. Participants had the right to withdraw from the study at any stage without providing a reason, and they would not be contacted further if they chose to discontinue.
7. The investigator remained available to address any questions or concerns raised by the participants and provided necessary clarifications whenever required.

3.6 Statistical Analysis Associated with Research Objectives and Hypotheses

After completing the scoring process according to the prescribed steps, the collected data was subjected to statistical analysis. All scoring was performed manually. Once the responses from all participants were scored and totalled for each variable, the data was systematically entered into an Excel sheet. The analysis was then conducted using Excel, SPSS, and AMOS.

Table 3.2 *Statistical Methods for Research Objectives and Hypotheses Testing*

S. No	Objective	Hypotheses	Research Technique
1.	To study sexual obsession in adults with OCD.	There will be no sexual obsessions in adults with OCD.	Descriptive Statistics (Frequency Distribution) of sexual obsession in OCD patients using SPSS.
2.	To identify religious obsession in adults with OCD.	There will be no religious obsession in adults with OCD.	Descriptive Statistics (Frequency Distribution) of religious obsession in OCD patients using SPSS version 26.
3.	To determine the clinical correlate (anxiety and depression) in adults with OCD.	There will be no clinical correlates (anxiety and depression) in adults with OCD	Correlation Analysis: Pearson's correlation coefficient to examine relationships between Anxiety, Depression, Quality of Life (QOL), Physical Health, Psychological, Social Relationships, and Environment in OCD patients using SPSS.
4.	To find the mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession with OCD.	There will be no mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession.	Structural Equation Modeling (SEM) using AMOS (version 23) to analyze mediation effects of anxiety and depression.

5.	To find the moderating effects of quality of life on people with sexual and religious obsessions in OCD.	There will be no moderating effects on the quality of life of people with sexual and religious obsessions in OCD.	Structural Equation Modeling (SEM) using AMOS (version 23) to analyze the moderating effects of quality of life.
6.	To examine the gender differences in adults having a sexual and religious obsession with OCD.	There will be no significant difference in adults having a sexual and religious obsession with OCD in relation to Gender.	Crosstab Analysis and Chi-Square Test using SPSS.
7.	To analyse the quality of life of people suffering from sexual and religious obsessions in OCD.	There will be no significant difference in the quality of life of people suffering from sexual and religious obsessions with OCD.	Descriptive Statistics (Frequency, Mean, Standard Deviation) and ANOVA (Analysis of Variance) using SPSS.

CHAPTER – IV

RESULTS

AND

DISCUSSION

CHAPTER – IV

RESULTS AND DISCUSSION

This chapter analyses data from 100 OCD patients at Ashoka Neuro Psychiatric Hospital, focusing on the prevalence and impact of sexual and religious obsessions, their clinical correlates (anxiety and depression), and quality of life. It examines gender differences and explores their implications for treatment and intervention. The findings highlight the distress caused by these obsessions, their association with mental health challenges, and their negative effect on daily functioning. By comparing results with existing research, this chapter provides insights into improving treatment strategies and enhancing the well-being of individuals with OCD.

4.1 Descriptive Analysis of OCD Patients: Demographics, Clinical Characteristics, and Severity of OCD Symptoms

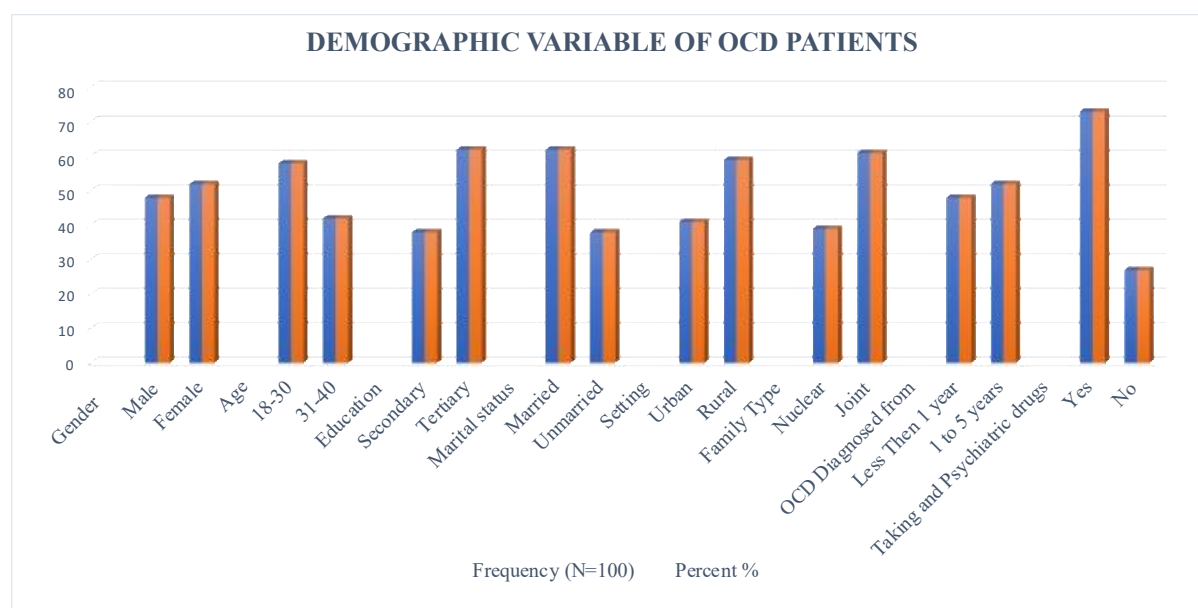
Descriptive statistics primarily consist of measures of central tendency and dispersion, which help in understanding the distribution patterns of scores and presenting data meaningfully. This section presents a comprehensive descriptive analysis of 100 patients diagnosed with Obsessive-Compulsive Disorder (OCD). It examines demographic variables, clinical characteristics, and the severity of obsession and compulsion symptoms. Additionally, the analysis includes the Yale-Brown Obsessive-Compulsive Scale-Symptom Checklist (YBOCS-SC) to categorise obsession and compulsion subtypes based on a Yes/No response format. Understanding these descriptive aspects provides essential insights into the symptom distribution and clinical presentation of OCD, serving as a foundation for further statistical analyses.

Table 4.1.1: *Demographic variables and clinical characters in patients with OCD.*

Variable	Frequency (N=100)	Percent (%)	M	SD
Gender				
Male	48	48.0%	28.68	6.85
Female	52	52.0%	28.82	5.33
Age				
18-30	58	58.0%	28.37	6.60
31-40	42	42.0%	29.28	5.29
Education				
Secondary	38	38.0%	28.50	6.17

Tertiary	62	62.0%	28.91	6.06
Marital status				
Married	62	62.0%	28.90	5.39
Unmarried	38	38.0%	28.52	7.12
Setting				
Urban	41	41.0%	28.31	5.88
Rural	59	59.0%	29.06	6.23
Family Type				
Nuclear	39	39.0%	27.76	6.53
Joint	61	61.0%	29.39	5.73
OCD Diagnosed from				
Less Than 1 year	48	48.0%	28.83	6.21
1 to 5 years	52	52.0%	28.69	6.00
Taking and Psychiatric drugs				
Yes	73	73.0%	28.71	6.30
No	27	27.0%	28.88	5.54

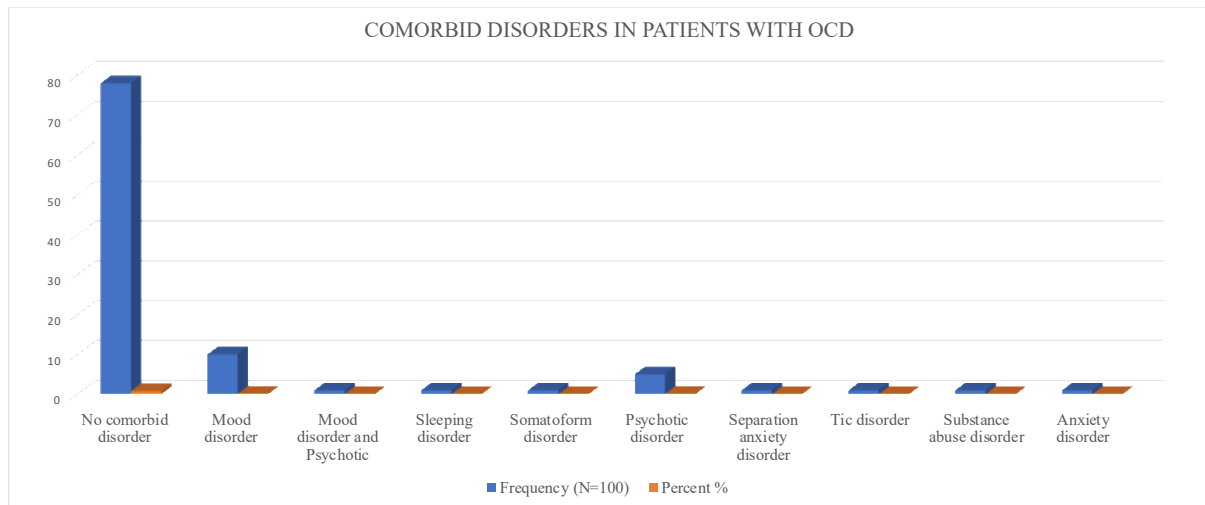
Figure 4.1.1: The bar graph shows the demographic variables and clinical characteristics of patients with OCD



Source: own data

Table 4.1.1 and Figure 4.1.1 provide a detailed overview of the demographic and clinical characteristics of OCD patients, along with their mean scores and standard deviations on a specific measure. The sample consists of a nearly equal distribution of genders, with slightly more females (52%) than males (48%). The mean scores for males ($M = 28.69$, $SD = 6.85$) and females ($M = 28.83$, $SD = 5.33$) are very similar, suggesting that there is not much significant difference in OCD severity between genders. Age-wise, most participants (58%) fall in the 18-30 age group, with a mean score of 28.38 ($SD = 6.61$), while those aged 31-40 (42%) have a slightly higher mean score of 29.29 ($SD = 5.30$), indicating marginally higher OCD scores among older participants. In terms of education, participants with tertiary education (62%) have a slightly higher mean score ($M = 28.92$, $SD = 6.07$) compared to those with secondary education ($M = 28.50$, $SD = 6.17$), indicating a small difference in scores based on education level. Regarding marital status, married individuals (62%) have a mean score of 28.90 ($SD = 5.40$), which is comparable to that of unmarried participants ($M = 28.53$, $SD = 7.12$), suggesting little difference in OCD severity based on marital status. Participants from rural settings (59%) have slightly higher mean scores ($M = 29.07$, $SD = 6.24$) compared to those from urban settings ($M = 28.32$, $SD = 5.89$). Family type shows more variability, with participants from joint families (61%) exhibiting higher mean scores ($M = 29.39$, $SD = 5.73$) than those from nuclear families ($M = 27.77$, $SD = 6.54$), suggesting that family structure might have some influence on OCD severity. The duration of OCD diagnosis reveals minimal differences, with those diagnosed for less than 1 year ($M = 28.83$, $SD = 6.22$) and those diagnosed for 1-5 years ($M = 28.69$, $SD = 6.01$) showing nearly identical scores, suggesting that OCD symptom severity remains relatively stable over the initial years after diagnosis. Similarly, psychiatric drug use shows little variation, with participants on medication (73%) having a mean score of 28.71 ($SD = 6.30$), slightly lower than those not on medication ($M = 28.89$, $SD = 5.54$), with a minimal difference in mean scores, indicating that taking psychiatric drugs may not result in a substantial reduction in symptom severity, as both groups have very similar average scores. Overall, there are some variations in mean scores across demographic and clinical variables.

Figure 4.1.2: The Bar Graph Shows The Comorbid Disorders in Patients with OCD



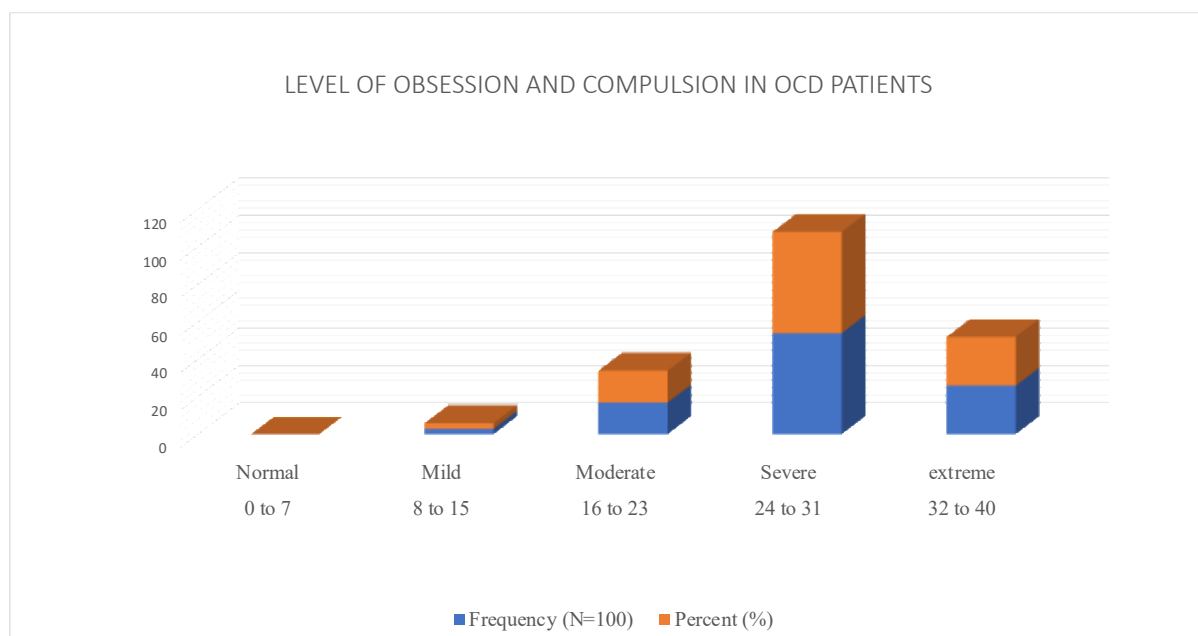
Source: own data

Figure 4.1.2 illustrates the distribution of comorbid disorders among 100 OCD patients. A significant majority of the sample, 78% (N=78), do not have any comorbid disorders. The most common comorbid disorder observed is mood disorder, present in 10% (N=10) of the patients. Psychotic disorders affect 5% (N=5) of the sample, making it the second most frequent comorbidity. Less common comorbidities, each affecting 1% (N=1) of the patients, include mood disorder with psychotic features, sleeping disorder, somatoform disorder, separation anxiety disorder, tic disorder, substance abuse disorder, and anxiety disorder. This distribution suggests that while most OCD patients in the sample do not have comorbid conditions, a minority presents with significant additional psychiatric challenges, particularly mood and psychotic disorders. This emphasises the need for comprehensive clinical assessments and tailored treatments for those with multiple diagnoses.

Table 4.1.2 : *The level of Obsession and Compulsion in OCD Patients.*

Score	Level	Frequency (N=100)	Percent (%)
0-7	Normal	0	0.0
8-15	Mild	3	3.0
16-23	Moderate	17	17.0
24-31	Severe	54	54.0
32-40	Extreme	26	26.0

Figure 4.1.3 : The bar graph shows the level of Obsession and Compulsion in OCD Patients



Source: own data

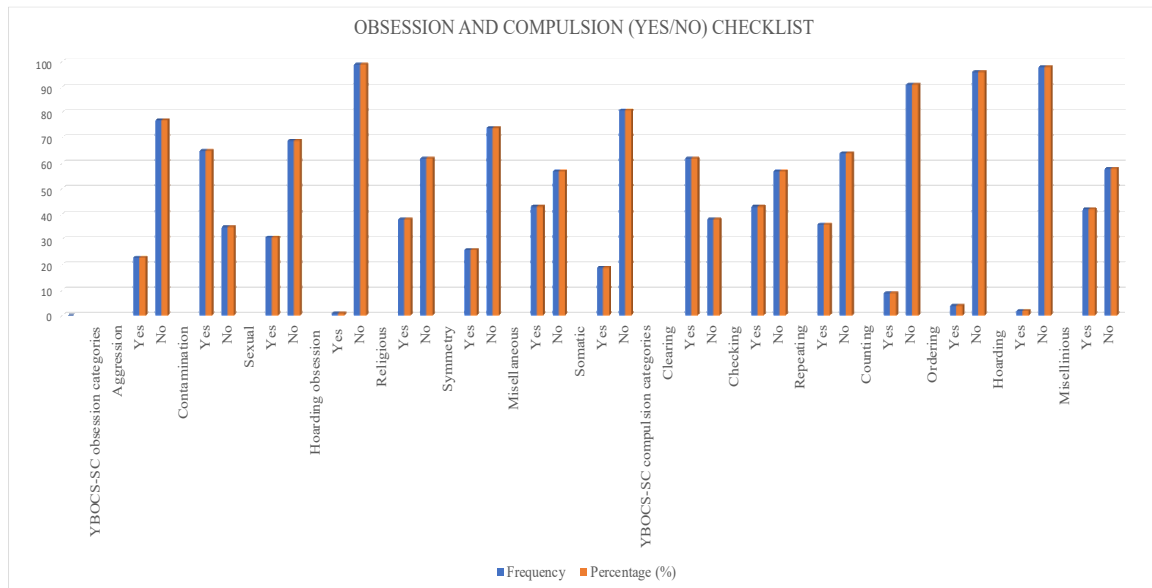
Table 4.1.2 and Figure 4.1.3 illustrate the severity levels of obsession and compulsion in 100 patients diagnosed with OCD. The majority of patients experience significant symptoms, with 54% categorised as having severe obsession and compulsion and 26% falling into the extreme range. A smaller proportion, 17%, exhibit moderate symptoms, while only 3% are classified as having mild symptoms. Notably, none of the patients are in the normal range (0%). This distribution indicates that obsessive-compulsive symptoms are generally severe or extreme in the majority of patients, which could significantly impact their quality of life and functioning. The graph visually supports these findings by showing a clear increase in frequency as the severity of symptoms rises.

Table 4.1.3 : YBOCS-SC obsession and compulsion categories checklist (Yes/No) in Patients with OCD.

Variable	Frequency (N=100)	Percentage (%)
YBOCS-SC obsession categories		
Aggression		
Yes	23	23.0%
No	77	77.0%
Contamination		
Yes	65	65.0%

No	35	35.0%
Sexual		
Yes	31	31.0%
No	69	69.0%
Hoarding obsession		
Yes	1	1.0%
No	99	99.0%
Religious		
Yes	38	38.0%
No	62	62.0%
Symmetry		
Yes	26	26.0%
No	74	74.0%
Misellaneous		
Yes	43	43.0%
No	57	57.0%
Somatic		
Yes	19	19.0%
No	81	81.0%
YBOCS-SC compulsion categories		
Clearing		
Yes	62	62.0%
No	38	38.0%
Checking		
Yes	43	43.0%
No	57	57.0%
Repeating		
Yes	36	36.0%
No	64	64.0%
Counting		
Yes	9	9.0%
No	91	91.0%
Ordering		
Yes	4	4.0%
No	96	96.0%
Hoarding		
Yes	2	2.0%
No	98	98.0%
Misellinious		
Yes	42	42.0%
No	58	58.0%

Figure 4.1.4 : The bar graph shows the YBOCS-SC obsession and compulsion categories checklist in Patients with OCD



Source: own data

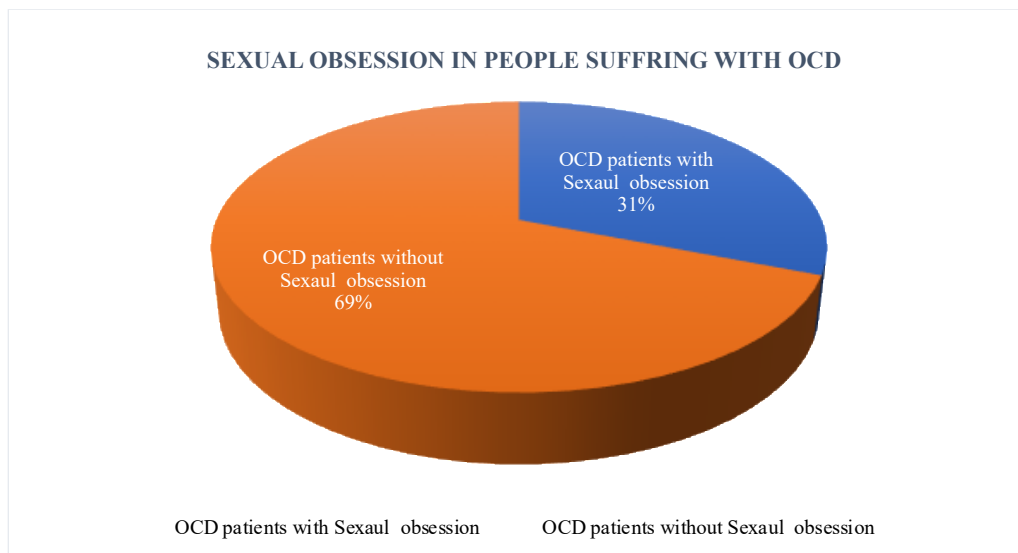
Table 4.1.3 and Figure 4.1.4 outline the frequency and percentage distribution of obsession and compulsion categories based on the Yale-Brown Obsessive Compulsive Scale Symptom Checklist (YBOCS-SC) for 100 OCD patients. In terms of obsessions, contamination is the most common, reported by 65% of the patients, followed by religious obsessions (38%) and miscellaneous obsessions (43%). Sexual obsessions are present in 31% of the sample. Aggressive obsessions are less common at 23%, while symmetry-related obsessions affect 26%. Hoarding obsessions are rare, occurring in only 1% of the participants. Regarding compulsions, cleaning is the most frequently reported compulsion, seen in 62% of the patients. Other common compulsions include checking (43%), miscellaneous compulsions (42%), and repeating (36%). Compulsions related to counting (9%), ordering (4%), and hoarding (2%) are relatively rare. Overall, the data reveal that contamination and religious and sexual obsessions, as well as cleaning and checking compulsions, are the predominant symptom patterns among OCD patients in this sample.

4.2 Prevalence and Severity of OCD Symptoms in Patients with Sexual and Religious Obsessions

This section presents visual representations of the prevalence and severity of OCD symptoms based on the presence of sexual and religious obsessions. It categorises individuals into four groups: those without sexual or religious obsessions, those with sexual obsessions, those with religious obsessions, and those with both. This analysis explores the prevalence of various obsessional themes within individuals with OCD and assesses their influence on symptom severity. By identifying the proportion of patients experiencing different degrees of severity, this section highlights the role of sexual and religious obsessions—whether present separately or simultaneously—in contributing to the overall impact of the disorder. These findings emphasise the importance of tailored interventions to reduce the distress and functional impairment related to these obsessional patterns.

Objective 1: To study sexual obsession in adults with OCD

Figure 4.2.1: Pie chart showing the prevalence of OCD patients with sexual obsession



Source: own data

Figure 4.2.1 presents a pie chart illustrating the distribution of sexual obsession prevalence among 100 individuals diagnosed with Obsessive-Compulsive Disorder (OCD), divided into two groups. The largest group (69%) consists of OCD patients without sexual obsessions, indicating that while OCD manifests in various ways, a significant portion does not experience these particular themes. However, a considerable prevalence (31%) of individuals suffer from

sexual obsessions—either alone (13%) or in combination with religious obsessions (18%). The presence of this large subgroup highlights the complex and often distressing nature of these symptoms, particularly for individuals whose religious beliefs may intensify feelings of guilt and anxiety. Studying the prevalence of sexual obsessions in OCD is crucial due to their significant impact on patient's mental health and their quality of life, yet it often goes unaddressed due to feelings of shame, guilt, social withdrawal, and a reluctance to seek help, as individuals may misinterpret them as moral failings rather than symptoms of a disorder (Pozza et al., 2020; Gordon, 2002). This can delay diagnosis and treatment, exacerbating emotional distress. Given its prevalence, sexual obsession is a critical aspect of OCD that requires careful attention and intervention to ensure that patients receive the appropriate care to manage this distressing symptom effectively.

4.2.2 Severity of OCD Symptoms in Patients with Sexual Obsessions

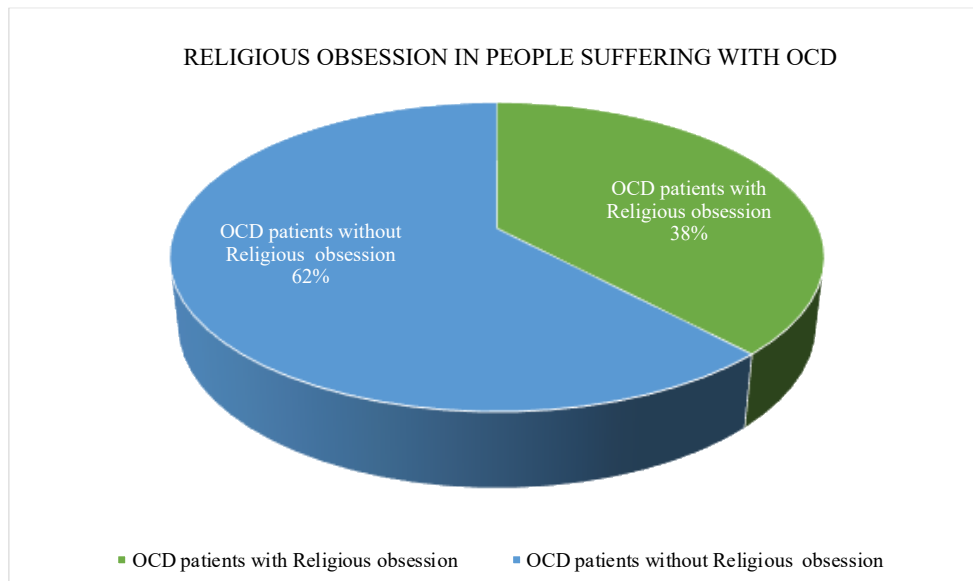
Table 4.2.2.1 : *The level of OCD patients with sexual obsession and compulsion*

Score	Level	Frequency (N=31)	Percent (%)
0-7	Normal	0	0
8-15	Mild	1	03.23
16-23	Moderate	2	06.45
24-31	Severe	16	51.61
32-40	Extreme	12	38.71

Table 4.2.2.1 exhibits the severity of sexual obsession and compulsion among the 31 OCD patients reveals that the majority of individuals experience significant distress. Over half of the sample (51.61%) fall within the severe category, while 38.71% are classified as having extreme levels of sexual obsession and compulsion. A smaller percentage of participants exhibit moderate symptoms (6.45%), and only one individual (3.23%) is in the mild category. Notably, no individuals fall into the normal range. These findings suggest that sexual obsessions and compulsions in this sample of OCD patients are generally severe or extreme in nature, indicating a substantial impact on their mental health

Objective 2: To identify religious obsession in adults with OCD.

Figure 4.2.2: Pie chart showing the prevalence of OCD patients with religious obsession



Source: own data

Figure 4.2.2 presents a pie chart illustrating the distribution of religious obsession prevalence among 100 individuals diagnosed with Obsessive-Compulsive Disorder (OCD), categorising them into two distinct groups. The largest segment (62%) consists of OCD patients without religious obsessions, indicating that while OCD manifests in various ways, a significant proportion do not experience these particular themes. However, a notable number (38%) of individuals suffer from religious obsessions, either alone ($n = 20$, 23%) or in combination with sexual obsessions ($n = 18$, 21%). This substantial subgroup highlights the complex and distressing nature of religious obsessions, particularly for individuals whose beliefs may intensify feelings of guilt, fear, and moral anxiety. Understanding the prevalence of religious obsessions in OCD is crucial due to their profound impact on patient's mental health and quality of life. These obsessions often revolve around intrusive thoughts related to blasphemy, morality, sin, or excessive religious rituals, leading to heightened distress and compulsive behaviours (Sharma et al., 2021). Moreover, the 21% of individuals experiencing both religious and sexual obsessions underscores the overlap between these themes, further complicating symptom presentation and treatment. Many patients struggle to seek help due to shame, fear of divine punishment, or social stigma, delaying diagnosis and proper treatment (Barman et al., 2023). Understanding this distribution is essential for clinicians and researchers, as religious

obsessions can have distinct clinical implications, often requiring targeted interventions and specialised therapeutic approaches.

4.2.3 Severity of OCD Symptoms in Patients with Religious Obsessions

Table: 4.2.3.2: *The level of OCD patients with Religious obsession and compulsion*

Score	Level	Frequency (N=38)	Percent (%)
0-7	Normal	0	0.0
8-15	Mild	0	0.0
16-23	Moderate	5	13.16
24-31	Severe	21	55.26
32-40	Extreme	12	31.58

Table 4.2.3.2 illustrates the severity levels of religious obsession and compulsion in individuals diagnosed with OCD. None of the participants fall within the normal (0-7) or mild (8-15) range, indicating that all individuals in the sample exhibit significant levels of religious obsession. A small proportion (13.16%) experience moderate symptoms, while the majority (55.26%) are classified as having severe levels of religious obsession and compulsion. Additionally, a considerable number of participants (31.58%) suffer from extreme symptoms. These findings highlight that the vast majority of individuals with religious obsession in OCD experience it at severe or extreme levels, suggesting a profound impact on their daily functioning and quality of life.

4.3 Clinical Correlates of Anxiety and Depression in Adults with OCD

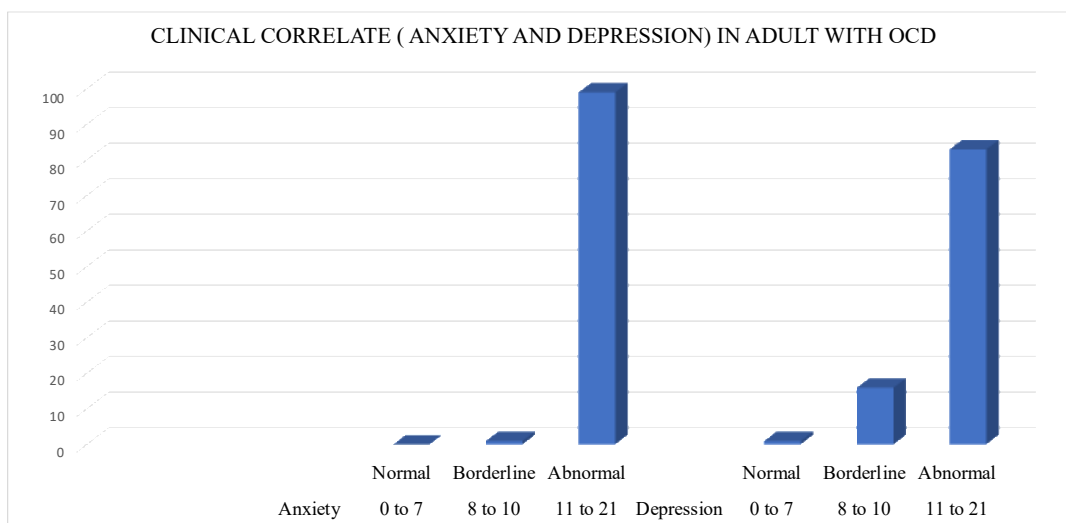
This section examines the occurrence, proportion, and interrelationships among anxiety, depression, and quality of life (QOL) in individuals with Obsessive-Compulsive Disorder (OCD). Pearson’s correlation analysis (Cohen, 1988) was employed to assess the associations between these psychological variables and their impact across various OCD subtypes. This method provides a systematic framework for evaluating how anxiety and depression interact with different QOL domains, including physical health, mental well-being, social interactions, and environmental influences. Gaining a deeper understanding of these connections offers valuable insights into the broader clinical implications of OCD and underscores the need for targeted interventions addressing the psychological distress associated with the disorder.

Objective 3: To determine the clinical correlates (anxiety and depression) in adults with OCD.

Table 4.3.1: *Frequency and Percentage of OCD Patients Across the Anxiety and Depression Scores*

Score	Level	Total Patients with OCD Frequency (N=100)
Anxiety		
0-7	Normal	0 (0.0%)
8-10	Borderline	1(1.0%)
11-21	Abnormal	99 (99.0%)
Depression		
0-7	Normal	1(1.0%)
8-10	Borderline	16 (16.0%)
11-21	Abnormal	83(83.0%)

Figure 4.3.1: *Bar graph showing the anxiety and depression in adults with OCD*



Source: own data

Table 4.3.1 and Figure 4.3.1 highlight a significant prevalence of anxiety and depression among individuals with OCD. Notably, 99% of the sample exhibited abnormal levels of anxiety, while only 1% fell within the borderline range, and no participants reported normal anxiety levels. This indicates that severe anxiety symptoms are highly prevalent among OCD patients. Similarly, the data on depression reveal that 83% of the sample experienced abnormal depressive symptoms, 16% were classified as having borderline depression, and only 1%

demonstrated normal depression levels. These findings suggest that the majority of individuals with OCD struggle with clinically significant anxiety and depressive symptoms, emphasizing the importance of addressing these comorbid conditions in the assessment and treatment of OCD.

Table 4.3.2: *Relationship among Anxiety, Depression, Quality of Life (QOL), Physical Health, Psychological, Social Relationships, and Environment in patients with OCD*

	Anxiety	Depression	QOL	Physical Health	Psychological Health	Social Relationships	Environment
1. Anxiety							
2. Depression	.436**						
3. QOL	-.500**	-.567**					
4. Physical Health	-.328**	-.380**	.740**				
5. Psychological Health	-.452**	-.493**	.768**	.466**			
6. Social Relationships	-.241*	-.266**	.628**	.499**	.216*		
7. Environment	-.411**	-.478**	.854**	.406**	.643**	.345**	

Note. ** Correlation is significant at the 0.01 level (2-tailed).

Note. * Correlation is significant at the 0.05 level (2-tailed).

Table 4.3.2 shows significant relationships between anxiety, depression, physical and psychological health, social relationships, and environmental factors in determining the quality of life (QOL) of individuals with Obsessive-Compulsive Disorder (OCD). There is a notable positive correlation between anxiety and depression ($r = .436$), indicating that higher levels of anxiety are associated with increased levels of depression among OCD patients. This suggests that the psychological burden of OCD often manifests in the form of comorbid emotional distress, further exacerbating the severity of symptoms. Additionally, both anxiety ($r = -.500$) and depression ($r = -.567$) demonstrate significant negative correlations with quality of life, emphasizing that as anxiety and depression levels increase, overall life satisfaction and well-being decrease.

Physical health has a significant positive correlation with QOL ($r = .740$), indicating that it is essential for enhancing QOL. This implies that physically healthier people have a higher quality of life. Conversely, physical health is negatively correlated with anxiety ($r = -.328$) and

depression ($r = -.380$), implying that poor physical well-being contributes to higher levels of emotional distress, further deteriorating mental health. Similarly, psychological health exhibits a strong positive correlation with QOL ($r = .768$) and is negatively correlated with anxiety ($r = -.452$) and depression ($r = -.493$). This indicates that better psychological health not only enhances overall well-being but also reduces the severity of anxiety and depression, thereby contributing to an improved quality of life for OCD patients.

Social relationships also play a vital role in the overall well-being of individuals with OCD, with a moderate positive correlation observed between social relationships and QOL ($r = .628$). Supportive social connections contribute to enhanced psychological resilience and coping mechanisms. Furthermore, social relationships are positively correlated with physical health ($r = .499$) and psychological health ($r = .216$), highlighting their role in fostering both physical and emotional well-being. A strong social support system can mitigate feelings of isolation, reduce distress, and promote better health outcomes.

Environmental factors exhibit the strongest positive correlation with QOL ($r = .854$), indicating that a favourable living environment significantly enhances life satisfaction in OCD patients. A positive environment provides stability, safety, and access to resources that facilitate better coping with OCD symptoms. Additionally, environmental factors are positively correlated with psychological health ($r = .643$) and social relationships ($r = .345$), reinforcing the notion that a supportive and structured environment not only improves psychological well-being but also fosters social connections.

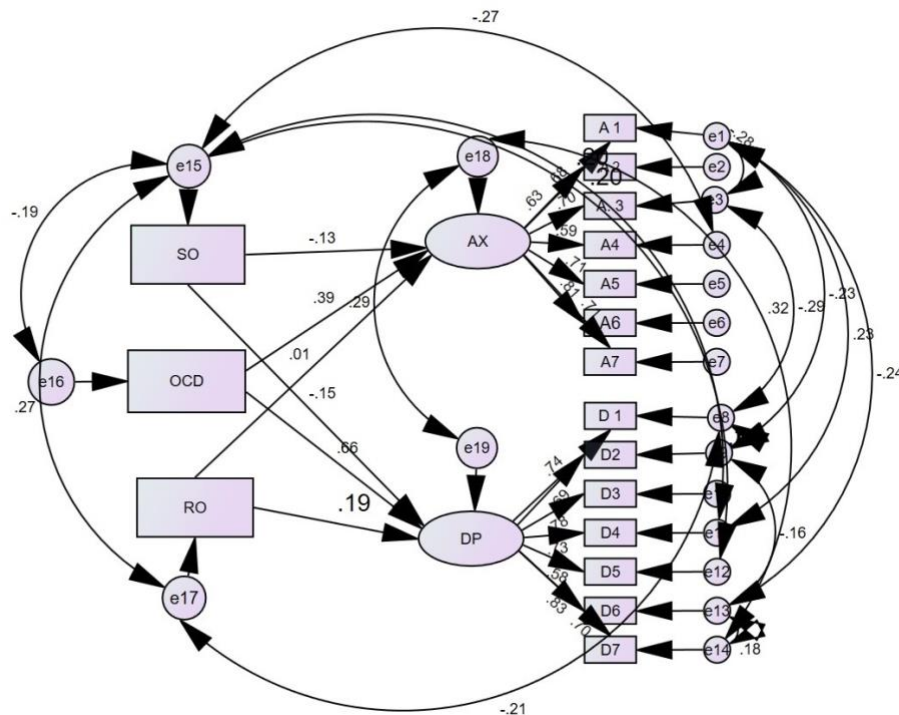
Overall, the correlations show that OCD patients' health and quality of life are negatively impacted by depression and anxiety. However, the right atmosphere, social connections, and improved physical and mental health are essential for improving one's overall quality of life. The strong link between these factors highlights the importance of a holistic approach in the treatment and care of individuals with OCD, focusing not only on reducing symptoms of anxiety and depression but also on enhancing overall health, social support, and environmental factors. The findings, therefore, show that anxiety and depression are significant clinical correlates in adults with OCD, having a significant impact on their quality of life, physical and psychological well-being, and social and environmental factors.

4.4 The Impact of Clinical Correlates (Anxiety and Depression) as Mediators In the Relationship Between Sexual and Religious Obsessions with OCD Severity

This section examines the mediation analysis of Anxiety (AX) and Depression (DP) in the relationship between Sexual Obsessions (SO) and Religious Obsessions (RO) with Obsessive-Compulsive Disorder (OCD). Following Baron and Kenny’s (1986) framework, mediation analysis identifies the indirect effects of these clinical correlates on OCD severity. Hayes (2013) underscores the significance of mediation in psychological research, highlighting its role in symptom development. Structural Equation Modeling (SEM) using AMOS software was employed to assess direct and indirect effects (Kline, 2016; Schumacker & Lomax, 2012). This approach provides deeper insight into the clinical profile of OCD, emphasising the mediating effects of anxiety and depression.

Objective 4: To find the mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession with OCD.

Figure 4.4.1: AMOS Drawing of the Mediation Effect Model



Source: own data

Table 4.4.1: Model Fit Evaluation

Fit Index	Value	Acceptable Threshold
Chi-Square	78.425	-
Degrees of freedom	100	-
Probability Level (p-value)	0.946	> 0.05
CMIN/DF	0.784	< 3
GFI	0.917	> 0.90
AGFI	0.873	> 0.80
CFI	1.000	> 0.90
RMSEA	0.000	< 0.06

The model in Table 4.4.1 demonstrates a firm fit to the data, with all key fit indices falling within acceptable or excellent ranges. The Chi-square value (78.425, $df = 100$, $p = 0.946$) is non-significant, indicating that the model does not significantly deviate from the observed data, which is a sign of a good fit. The CMIN/DF ratio of 0.784 is well below the commonly accepted threshold of 3, further confirming a well-fitting model (Hayduk, 2018). Additionally, the Goodness-of-Fit Index (GFI) of 0.917 and the Adjusted Goodness-of-Fit Index (AGFI) of 0.873 suggest an acceptable to good model fit (Hooper, Coughlan, & Mullen, 2008). The Comparative Fit Index (CFI) of 1.000 represents an excellent fit, as values close to or above 0.95 indicate a good fit (Hu & Bentler, 1999). The Root Mean Square Error of Approximation (RMSEA) of 0.000 is ideal, as values below 0.06 are considered indicative of a strong model fit (Hu & Bentler, 1999). These results suggest that the proposed model effectively represents the observed data.

Table 4.4.2: Results of Direct Effects Without Mediation

Path	Regression Weight (β)	S.E.	C.R.	p-value
OCD \rightarrow Anxiety	0.394	0.007	3.746	***
OCD \rightarrow Depression	0.662	0.009	6.572	***
Sexual Obsession \rightarrow Anxiety	-0.132	0.092	-1.329	0.184
Sexual Obsession \rightarrow Depression	-0.149	0.107	-1.736	0.083
Religious Obsession \rightarrow Anxiety	0.011	0.082	0.120	0.905
Religious obsession \rightarrow Depression	0.193	0.098	2.279	0.023

* $P < .05$, * * $P < .01$, *** $P < .001$

The results from Table 4.4.2 of the structural equation model (SEM) indicate that OCD significantly predicts both anxiety and depression ($p < 0.001$), suggesting that higher OCD severity is associated with increased levels of anxiety and depression. Additionally, religious obsession significantly predicts depression ($p = 0.023$), indicating that individuals experiencing religious obsessions tend to have higher levels of depressive symptoms. However, sexual obsession (SO) does not significantly predict either anxiety or depression, implying that sexual obsession alone does not strongly contribute to these clinical correlates. Furthermore, religious obsession does not significantly predict anxiety, suggesting that religious obsessions are not a strong determinant of anxiety levels. These findings highlight the differential impact of religious and sexual obsessions on emotional distress in individuals with OCD.

Table: 4.4.3 Result of Mediation Analysis (Indirect Effects)

Mediation Path	Computed Effect (β)	P-value
Sexual obsession \rightarrow Depression \rightarrow OCD	$-0.149 \times 0.662 = -0.0988$	0.083
Religious obsession \rightarrow Depression \rightarrow OCD	$0.193 \times 0.662 = 0.127$	0.023*
Sexual obsession \rightarrow Anxiety \rightarrow OCD	$-0.132 \times 0.394 = -0.0519$	0.184
Religious obsession \rightarrow Anxiety \rightarrow OCD	$0.011 \times 0.394 = 0.0043$	0.905

* $P < .05$, * * $P < .01$, *** $P < .001$

Table 4.4.3 presents the results of the mediation analysis. The findings indicate that depression significantly mediates the relationship between religious obsession and OCD ($\beta = 0.127$), as both the path from religious obsession to depression and from depression to OCD were statistically significant. This suggests a partial mediation, wherein religious obsessions indirectly influence OCD severity through elevated depressive symptoms. In contrast, the mediation path from sexual obsession to OCD via depression was not statistically significant ($\beta = -0.0988$, $p = 0.083$), indicating that depression does not serve as a mediator in this relationship. Additionally, both mediation paths involving anxiety—Sexual Obsession \rightarrow Anxiety \rightarrow OCD and Religious Obsession \rightarrow Anxiety \rightarrow OCD—were found to be non-significant ($p = 0.184$ and $p = 0.905$, respectively).

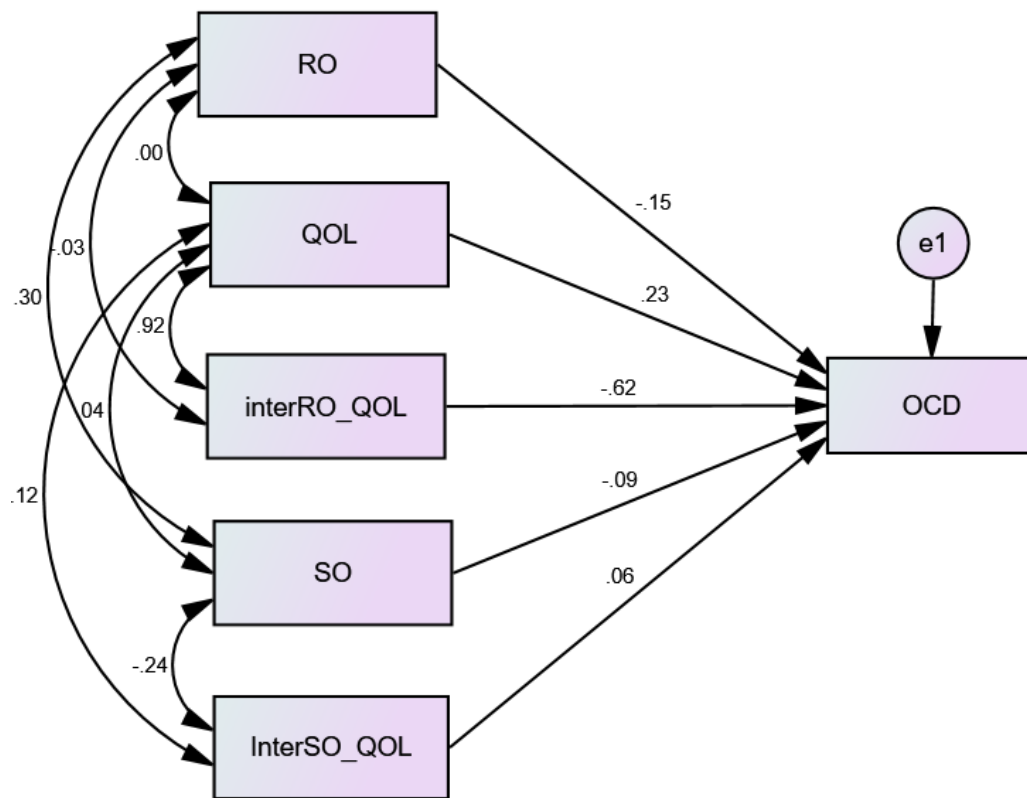
Overall, these findings demonstrate a partial mediation effect: depression mediates the relationship between religious obsession and OCD, although anxiety does not mediate sexual or religious obsessions. Furthermore, depression does not serve as a mediator between sexual obsession and OCD.

4.5: Moderating Role of Quality of Life in the Relationship Between Religious and Sexual Obsessions with OCD Severity

This section presents the results of the moderation analysis, examining the role of Quality of Life (QOL) in the relationship between Religious Obsessions (RO) and Sexual Obsessions (SO) with OCD severity. Moderation analysis was conducted following the framework outlined by Hayes (2013), which emphasises how an interaction term influences the strength or direction of a relationship. A Structural Equation Model (SEM) was employed using AMOS software to assess direct, indirect, and interaction effects (Kline, 2016; Schumacker & Lomax, 2015). The analysis includes a moderation table displaying statistical estimates, significance levels, and interaction effects, complemented by graphical representations of QOL's moderating role. Additionally, covariance and correlation analyses explore the relationships between RO, SO, QOL, and their interaction terms, offering a comprehensive understanding of OCD severity and its clinical implications.

Objective 4: To find the moderating effects of quality of life of people with sexual and religious obsessions in OCD.

Figure 4.5.1: AMOS Drawing of the Moderation Effect Model



Source: own data

Table 4.5.1: Moderation Analysis

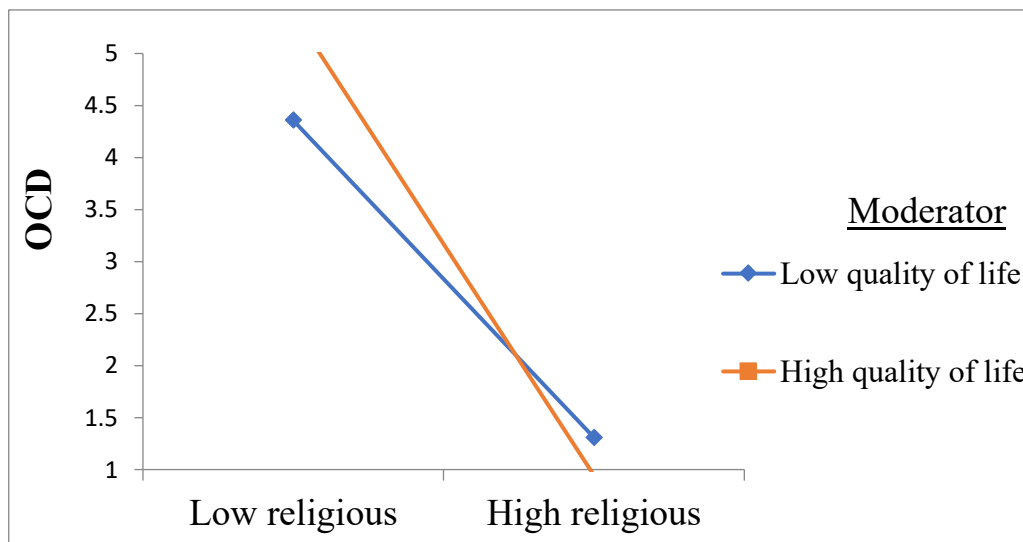
Predictor	Estimate	S.E.	C.R.	P-value
RO → OCD	-1.874	1.149	-1.631	.103
SO → OCD	-1.209	1.235	-0.979	.327
QOL → OCD	0.168	0.170	0.985	.325
InterRO_QOL → OCD	-0.350	0.132	-2.657	.008*
InterSO_QOL → OCD	0.084	0.132	0.637	.524

* $P < .05$, ** $P < .01$, *** $P < .001$

Table 4.5.1 and Figure 4.5.1 highlight the differential role of QOL in moderating the effects of religious and sexual obsessions on OCD severity. The findings indicate that neither Religious Obsessions (RO) nor Sexual Obsessions (SO) significantly predict OCD symptoms ($p = .103$

and .327, respectively). Additionally, Quality of Life (QOL) does not have a direct effect on OCD symptoms ($p = .325$), suggesting that overall well-being alone does not influence OCD severity. However, the interaction term for religious obsessions and quality of life (InterRO_QOL) is significant ($\beta = -0.350$, $p = .008$), indicating that QOL moderates the relationship between religious obsessions and OCD symptoms. This suggests that the impact of religious obsessions on OCD symptoms varies depending on an individual's quality of life. Conversely, the interaction between sexual obsessions and quality of life (InterSO_QOL) is not significant ($\beta = 0.084$, $p = .524$), implying that QOL does not moderate the relationship between sexual obsessions and OCD symptoms.

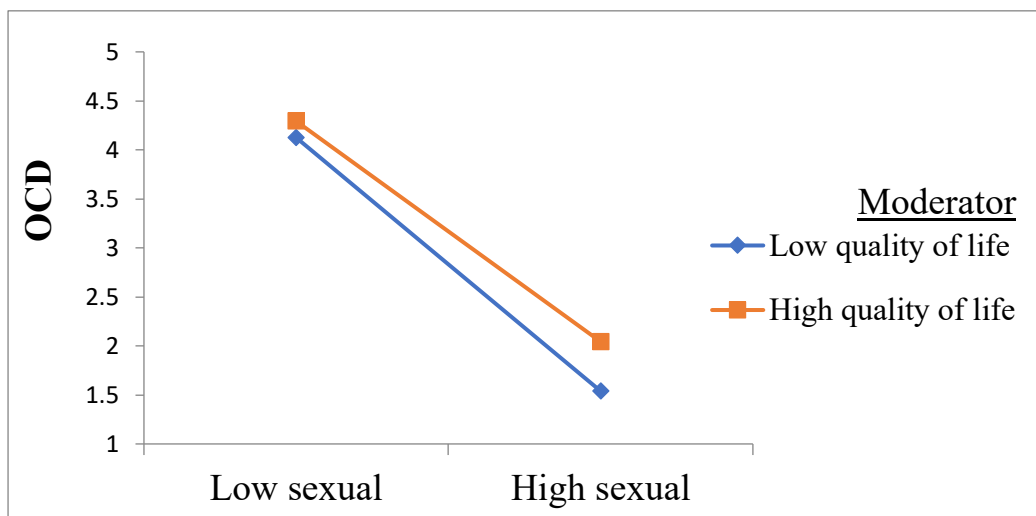
Figure 4.5.2: Simple Slope Graph for the Moderation Effect of Quality of Life on the Relationship Between Religious Obsessions and OCD Severity



Source: own data

Figure 4.5.2 illustrates the moderation effect of Quality of Life (QOL) on the relationship between Religious Obsessions and OCD severity. The steeper slope for high QOL suggests that as religious obsessions increase, OCD symptoms decrease more sharply for individuals with high QOL compared to those with low QOL. This indicates that higher QOL helps mitigate the negative impact of religious obsessions on OCD, leading to an overall better mental health outcome.

Figure 4.5.3: Simple Slope Graph for the Moderation Effect of Quality of Life on the Relationship Between Sexual Obsessions and OCD Severity



Source: own data

Figure 4.5.3 presents a simple slope graph depicting the relationship between sexual obsessions, OCD severity, and the moderating role of quality of life (QOL). The results indicate that QOL does not significantly moderate the relationship between sexual obsessions and OCD severity, as shown by the nearly parallel slopes. This suggests that regardless of whether individuals have high or low QOL, the effect of sexual obsessions on OCD remains stable. Interestingly, individuals with higher QOL consistently report higher OCD severity at both low and high levels of sexual obsessions. One possible explanation is that sexual obsessions, unlike religious obsessions, may be associated with greater distress, shame, or internal conflict, which persist despite overall life satisfaction or well-being (Boger et al., 2020). Unlike religious obsessions, which may be alleviated through social support, spiritual coping, or cognitive reframing, sexual obsessions may be more stigmatised or difficult to manage, leading to sustained OCD severity regardless of QOL (Gordon, 2002). This highlights the need for targeted interventions addressing the unique distress caused by sexual obsessions in OCD (Gordon, 2002).

Table 4.5.2: Covariances and Correlation

Variables	Estimate	S.E.	C.R.	P-value
RO ↔ QOL	0.011	0.382	0.029	.977
interRO_QOL ↔ QOL	79.270	11.742	6.751	***
RO ↔ interRO_QOL	-0.161	0.491	-0.327	.743
QOL ↔ SO	0.135	0.153	0.886	.376
InterSO_QOL ↔ SO	-0.487	0.200	-2.437	.015
QOL ↔ InterSO_QOL	-4.340	1.495	-2.904	.004
RO ↔ SO	0.068	0.023	2.931	.003

Table 4.5.2 highlights the complex relationships between religious and sexual obsessions, quality of life (QOL), and their interaction effects on OCD severity. While RO and QOL do not significantly covary ($p = .977$), QOL strongly influences the interaction term interRO_QOL ($\beta = 79.270$, $p < .001$). Similarly, no significant relationship is found between QOL and SO ($p = .376$). However, a moderate negative association between InterSO_QOL and SO ($\beta = -0.487$, $p = .015$) suggests that as sexual obsessions increase, their interaction effect with QOL decreases. Additionally, higher QOL is associated with a lower interaction effect between SO and OCD ($\beta = -4.340$, $p = .004$). Lastly, a significant positive relationship between RO and SO ($\beta = 0.068$, $p = .003$) suggests that individuals with high religious obsessions are also likely to experience sexual obsessions. These findings emphasise the distinct roles of QOL in moderating religious and sexual obsessions and their impact on OCD severity.

Overall, the findings show that there is a partial moderation effect, while QOL does not moderate sexual obsessions but does moderate religious obsessions. This means that while QOL does not influence the impact of sexual obsessions on OCD, it does play a role in moderating the relationship between religious obsessions and OCD.

4.6: Gender Distribution and Differences in OCD Patients with Sexual and Religious Obsessions

This section examines gender differences in the prevalence of sexual and religious obsessions across OCD subtypes using crosstab analysis and chi-square tests. Chi-square is suited for categorical data, so it is an appropriate method for analysing male-female differences (Tabachnick & Fidell, 2019). To ensure statistical validity, chi-square tests require expected

frequencies of at least five per cell (McHugh, 2013) and are generally reliable with a minimum sample size of 50, particularly in 2×2 tables (Nisen & Schwertman, 2008). The results determine whether observed gender differences are statistically significant or due to random variation.

Objective 6: To examine the gender differences in adults having a sexual and religious obsession with OCD.

Table 4.6.1: *Crosstab Analysis (Frequency Distribution) for Gender Distribution in Sexual Obsession*

Gender	OCD with Sexual Obsession	OCD with both Religious and sexual obsession	OCD without Sexual Obsession	Total
Male	8	12	28	48
Female	5	6	41	52
Total	13	18	69	100

Table 4.6.1 presents the frequency distribution of gender differences in sexual obsession categories. The results revealed some noticeable differences in the distribution of obsession types between genders. Males exhibited a slightly higher proportion in the 'OCD with both obsessions' category, with 12 males compared to 6 females. Conversely, females were more frequently categorised in the 'OCD without sexual obsession' group, with 41 females compared to 28 males. While these differences suggest some variation in the distribution of obsession types across genders, a chi-square test was conducted to determine whether these observed differences were statistically significant.

Table 4.6.2: *Crosstab Analysis (Frequency Distribution) for Gender Distribution in Religious Obsession*

Gender	OCD with Religious Obsession	OCD with both Sexual and Religious obsession	OCD without Religious Obsession	Total
Male	7	12	29	48
Female	13	6	33	52
Total	20	18	62	100

Table 4.6.2 shows the frequency distribution of gender differences in religious obsession categories. The results indicated some differences between genders. Females were more frequently categorised in the ‘OCD with religious obsession only’ category, with 13 females compared to 7 males. Conversely, males were more prevalent in the ‘OCD with both obsessions’ category, with 12 males compared to 6 females. Although these differences suggest some variation in the distribution of religious obsession patterns, a chi-square test was conducted to determine whether these observed differences were statistically significant.

Table 4.6.3: *Chi-Square Test Results for Sexual Obsession*

Test Statistic	Value	df	P-Value
Pearson Chi-Square	4.990	2	.083
Likelihood Ratio	5.041	2	.080
Linear-by-Linear Association	2.888	1	.089

Table 4.6.3 presents the chi-square test results evaluating gender differences in obsession categories. The Pearson Chi-Square test for sexual obsession yielded a value of 4.990 with 2 degrees of freedom and a p-value of .083. As this p-value exceeds the .05 significance threshold, the result is not statistically significant. Consequently, the observed differences in frequency distribution are likely attributable to random variation rather than a true gender-based pattern.

Table 4.6.4: *Chi-Square Test Results for Religious Obsession*

Test Statistic	Value	df	P-Value
Pearson Chi-Square	3.904	2	.142
Likelihood Ratio	3.965	2	.138
Linear-by-Linear Association	.209	1	.648

Table 4.6.4 presents the chi-square test results examining the statistical significance of gender differences in the obsession categories. The Pearson Chi-Square test for religious obsession produced a value of 3.904 with 2 degrees of freedom and a p-value of .142. As the p-value exceeds the .05 threshold, the result is not statistically significant, indicating no meaningful association between gender and religious obsession categories.

Homogeneity of Expected Counts

The assumption of homogeneity in expected counts was satisfied in both chi-square tests. Specifically, no cells (0%) had expected counts below 5, and the minimum expected count was sufficiently high. This ensures that the chi-square test results are valid and reliable.

Overall, the chi-square test results indicated no significant gender differences in the distribution of obsession types. For sexual obsessions, the p-value of .083 exceeded the conventional significance threshold of .05, suggesting that the observed differences between males and females were not statistically significant. Similarly, for religious obsessions, the p-value of .142 also exceeded the .05 threshold, confirming that the observed gender differences were not significant. These findings suggest that variations in obsession patterns across genders may be due to chance rather than a meaningful association.

4.7: Quality of Life In OCD Patients with Sexual and Religious Obsessions: Subtype Comparison and ANOVA Analysis

This section presents the frequency and percentage distribution of Quality of Life (QoL) scores among OCD patients with and without sexual and religious obsessions. It also includes a comparative analysis across OCD subtypes and an ANOVA test to determine whether there are significant differences in QoL scores between individuals with sexual obsession, religious obsession, both sexual and religious obsessions and those without these obsessions. ANOVA

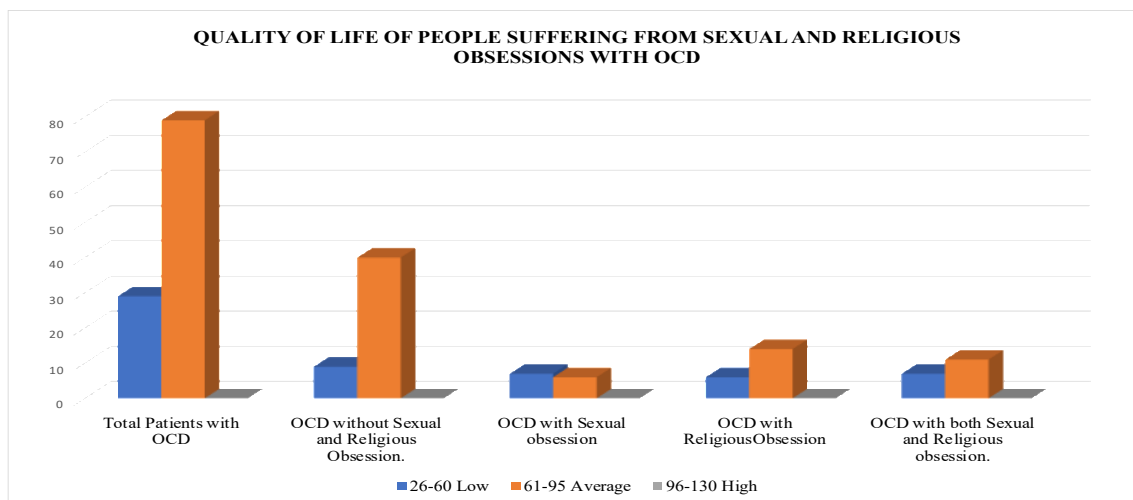
is particularly suitable for comparing means across multiple groups, assuming normality and homogeneity of variance, which are typically checked before applying the test (Tabachnick & Fidell, 2019).

Objective 7: To analyse the quality of life of people suffering from sexual and religious obsessions in OCD.

Table 4.7.1: *Distribution of Quality of Life Scores Across Different OCD Subtypes.*

Score	Level	Total Patients with OCD Frequency (N=100)	OCD without Sexual and Religious Obsession. Frequency (N=49)	OCD with Sexual obsession. Frequency (N=13)	OCD with Religious Obsession. Frequency (N=20)	OCD with both Sexual and Religious obsession. Frequency (N=18)
26-60	Low	29 (29.0%)	9 (18.63%)	7 (53.8%)	6 (30%)	7 (50.00%)
61-95	Average	79 (71.0%)	40 (81.63%)	6 (46.1%)	14 (70%)	11(61.11%)
96-130	High	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

Figure 4.7.1: *Bar chart showing the Quality of life of people suffering from OCD*



Source: own data

Table 4.7.1 and Figure 4.7.1 show the distribution of quality of life (QOL) ratings among OCD patients. Notably, none of the patients reported having a great quality of life, demonstrating that OCD has a major influence on general well-being, independent of obsessive type. The majority of OCD patients, which is 71%, have an average QOL, indicating that while their quality of life is modestly impacted, they still experience functional impairment. Among individuals without sexual or religious obsessions, 81.63% rated average QOL, while only 18.63% reported low QOL, showing a higher quality of life than those with specific obsessional themes. Patients with sexual obsessions (53.8%) and those with both sexual and religious obsessions (50%) show the highest proportion of low QOL scores, suggesting that these symptom dimensions are associated with greater distress and functional impairment. Patients with religious obsessions alone exhibit a relatively lower impact on QOL, with 30% scoring in the low range and 70% in the average range. This suggests that the coexistence of sexual and religious obsessions may have a more detrimental impact on life quality, likely due to heightened distress, guilt, and cognitive dissonance associated with these themes. The most substantial impairment across all subgroups was observed in the social relationship domain, suggesting that interpersonal difficulties are a prominent feature of OCD, especially in individuals with sexual obsessions. These findings highlight that OCD, particularly when involving sexual and religious obsessions, significantly impairs quality of life, emphasising the need for targeted therapeutic interventions to address the unique distress associated with these obsessions.

Table 4.7.2 : Quality of Life Dimensions in Patients with OCD

Score	Level	Total Patients with OCD Frequency (N=100)	OCD without Sexual and Religious Obsession. Frequency (N=49)	OCD with Sexual obsession. Frequency (N=13)	OCD with Religious Obsession. Frequency (N=20)	OCD with both Sexual and Religious obsession. Frequency (N=18)
Psychical Health						
7-16	Low	59 (59.0%)	23 (46.94%)	11(84.6%)	13 (65.0%)	12 (66.67%)
17-25	Average	41 (41.0%)	26 (53.06%)	2 (15.4%)	7 (35.0%)	6 (33.33%)
26 and above	High	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Psychological Health						

6-13	Low	49 (49.0%)	26 (53.06%)	7 (53.8%)	9 (45%)	7 (38.89%)
14-22	Average	41 (41.0%)	23 (46.94%)	6 (46.2%)	11 (55%)	11 (61.11%)
23 and above	High	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Social Relationship						
5-8	Low	75 (75.0%)	31 (63.27%)	12 (92.3%)	16(80%)	15 (83.33%)
9-12	Average	25 (25.0%)	18 (36.73%)	1 (7.7%)	4 (20%)	2 (11.11%)
13 and above	High	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Environmental						
8-18	Low	6 (6.0%)	1 (2.04%)	4 (30.8%)	0 (0.0%)	1 (5.56%)
19-29	Average	84 (84.0%)	42 (85.71%)	8 (61.5%)	18(90%)	14 (77.78%)
30 and above	High	10 (10.0%)	4 (8.16%)	1 (7.7%)	2 (10%)	13 (16.675)

Table 4.7.2 provides a comparative overview of the quality of life (QOL) dimensions among OCD patients, distinguishing between those with and without sexual and religious obsessions. Across all domains—physical health, psychological well-being, social relationships, and environmental factors—individuals experiencing sexual and/or religious obsessions report a lower QoL compared to those without these specific obsessions. In the physical health domain, 59% of all OCD patients fall into the low QOL category. The greatest impairment is observed in those with sexual obsessions (84.6%), followed by individuals with both sexual and religious obsessions (66.67%) and religious obsessions alone (65%). In contrast, those without these obsessions exhibit relatively better physical health, with 53.06% scoring in the average range.

For psychological health, nearly half of the sample (49%) experiences low QoL, with similar trends across all OCD subgroups. Patients with both sexual and religious obsessions show a slightly better psychological health status, with 61.11% falling into the average range. However, no participants across any subgroup report high psychological health scores, highlighting the substantial emotional burden of OCD. The social relationship domain emerges as the most significantly affected, with 75% of all OCD patients scoring in the low category. The highest level of impairment is seen in those with sexual obsessions (92.3%), followed by those with both sexual and religious obsessions (83.33%) and religious obsessions alone (80%). This suggests that these obsessions may lead to severe social difficulties, likely due to stigma,

distress, and interpersonal challenges. Regarding environmental QOL, the majority of participants (84%) fall within the average range, though those with sexual obsessions show the highest level of impairment (30.8% in the low category). A small proportion of patients, particularly those without sexual or religious obsessions, report a high QOL in this domain (10%). These findings suggest that OCD substantially impacts various aspects of quality of life, with sexual and religious obsessions contributing to greater impairment in physical health, psychological well-being, and social functioning. These results underscore the importance of specialised interventions to address both the symptomatic and quality-of-life challenges associated with OCD, particularly in patients struggling with sexual and religious obsessions.

Table 4.7.3: *Descriptive Statistics for Overall Quality of Life with Skewness and Kurtosis*

Quality of Life	N	M	SD	Skewness	Kurtosis
	100	65.09	8.50	-0.412	-0.633

Table 4.7.3 illustrates the quality of life data for 100 participants, showing a mean score of 65.09 with a standard deviation of 8.50. The skewness value of -0.412 suggests a slight left (negative) skew, while the kurtosis value of -0.633 indicates a somewhat flatter distribution than a perfect normal curve. However, both values are relatively close to zero, suggesting that the overall distribution does not deviate substantially from normality.

Table 4.7.4: *Levene's Test for Homogeneity of Variance*

Levene's Statistic	df1	df2	Sig.
2.514	3	96	0.063

Table 4.7.4 presents Levene's test for variance homogeneity, which determines if the variances are identical across the groups. Levene's statistic for this example is 2.514, with degrees of freedom $df1 = 3$ and $df2 = 96$. The p-value is 0.063. Considering this p-value is higher than the usually recognised significance level of 0.05, we infer that there is no significant difference in variances between the groups. This implies that the premise of equal variances across groups has been satisfied, allowing us to compare the means using ANOVA.

Table 4.7.5 *Descriptive statistics of quality of life in OCD subtypes (data confirmed as normally distributed)*

Group	N	M	SD
OCD without Sexual and Religious obsession	49	67.25	7.03
OCD with Sexual obsession	13	58.92	11.07
OCD with Religious obsession	20	65.75	7.28
OCD with both Sexual and Religious obsession	18	62.94	9.39

The findings from Table 4.7.5 illustrate the quality of life scores for each group; several characteristics can be observed. Individuals with OCD without sexual and religious obsessions, with a mean score of 67.25, experience the best quality of life, suggesting that the absence of these specific obsessions is associated with fewer disruptions in daily functioning. In contrast, those with OCD involving sexual obsessions report the lowest quality of life, with a mean score of 58.92, indicating that sexual obsessions may have a particularly severe negative impact on overall well-being. The OCD in the religious obsession group, with a mean score of 65.75, exhibits a quality of life that is slightly lower than that of individuals with OCD without the sexual and religious obsession group but better than the sexual obsession group, suggesting that religious obsessions have a somewhat less profound effect compared to sexual obsessions. Finally, individuals with both sexual and religious obsessions have a mean score of 62.94, which is lower than that of the religious obsession group yet slightly better than that of the sexual obsession group, indicating that while the combination of obsessions leads to impaired functioning, the severity is not as high as in those struggling only with sexual obsessions.

Although individuals with both sexual and religious obsessions reported slightly better QOL than those with only sexual obsessions, further analysis is needed to confirm if this difference is statistically significant (Kim, 2014).

Overall, sexual obsession appears to have the most detrimental effect on quality of life, with religious obsession having a somewhat lesser impact, and the complexity of impairment generally increases when both types of obsessions are present.

Table 4.7.6: *One-Way ANOVA Results for Quality of Life Among OCD Subtypes (Sexual and Religious Obsessions)*

S.O.V	df	SS	MS	F	Sig.
Between groups	3	813.51	271.17		
				4.102	0.009
Within groups	96	6346.68	66.11		
Total	99	7160.91			

The findings from Table 4.7.6 indicate that there is a statistically significant difference in the quality of life of people with different types of OCD, specifically about sexual and religious obsessions. The degrees of freedom between groups is 3, and the sum of squares (SS) between groups is 813.51, with a mean square (MS) of 271.17. The F statistic is 4.102, which is associated with a p-value of 0.009. Since the p-value is less than the commonly accepted significance level of 0.05, the quality of life of people suffering from sexual and religious obsessions in OCD differs significantly among at least two of the subgroups (i.e., individuals with sexual obsessions, religious obsessions, both sexual and religious obsessions and without these obsessions). Although the ANOVA shows significant differences across groups ($p = 0.009$), additional post hoc tests are necessary to identify the individual groups that differ significantly (Hugh, 2011).

Table 4.7.7: *Tukey HSD Post Hoc Test for Quality of Life Differences Among OCD Subgroups*

Group Comparison	Mean Difference	p-value
OCD without Sexual and Religious obsessions vs. OCD with Sexual obsessions	8.32	0.008
OCD without Sexual and Religious obsessions vs. OCD with Religious obsessions	1.49	0.900
OCD without Sexual and Religious obsessions vs. OCD with Both Sexual and Religious obsessions	4.30	0.227
OCD with Sexual obsessions vs. OCD with Both Sexual and Religious obsessions	-6.83	0.093

OCD with Religious obsessions		
OCD with Sexual obsessions vs.		
OCD with Both Sexual and Religious obsessions	-4.02	0.528
OCD with Religious obsessions vs.		
OCD with Both Sexual and Religious obsessions	2.81	0.713

The Tukey HSD post hoc test findings, shown in Table 4.7.7, indicated a significant difference in quality of life (QOL) scores between the OCD subgroups with and without sexual and religious obsessions ($p = 0.008$). This research suggests that those with sexual obsessions have a much lower quality of life than people who don't have sexual or religious obsessions. However, no other subgroup comparisons reached statistical significance. Although some mean differences, such as the 6.83-point gap between the sexual and religious obsession groups, suggested potential trends, these differences were not statistically significant. This pattern underscores the distinct impact of sexual obsessions on QOL within the OCD population.

4.8 Discussion and Interpretation of Findings

The discussion of the study findings is structured around the research objectives and hypotheses, focusing on the key variables of the current study. These variables include sexual obsession, religiosity, clinical correlates (anxiety and depression), and quality of life among people with obsessive-compulsive disorder (OCD).

4.8.1 Demographic Variable of OCD Severity

The study findings indicate that demographic factors exert minor yet notable influences on OCD severity. Gender differences were not significant, as both males ($M = 28.69$, $SD = 6.85$) and females ($M = 28.83$, $SD = 5.33$) exhibited similar symptom severity, consistent with prior research suggesting that OCD affects both genders equally in terms of severity, though symptom expression may vary (Barman et al., 2023). Age-related differences suggest a potential trend of increasing severity with age, as participants aged 31-40 had slightly higher mean scores ($M = 29.29$, $SD = 5.30$) than younger individuals ($M = 28.38$, $SD = 6.61$), aligning with findings that OCD symptoms often persist and intensify over time (Stein et al., 2019).

Educational attainment showed minimal impact, with tertiary-educated individuals ($M = 28.92$, $SD = 6.07$) exhibiting slightly higher severity than those with secondary education ($M = 28.50$, $SD = 6.17$), possibly due to heightened cognitive awareness and anxiety processing (Baranova et al., 2024). Similarly, marital status did not significantly affect OCD severity, as married ($M = 28.90$, $SD = 5.40$) and unmarried individuals ($M = 28.53$, $SD = 7.12$) reported comparable scores, in line with studies emphasising the psychosocial burden of OCD without clear severity differences (Singh et al., 2022).

Residential background and family structure revealed minor variations, with rural participants ($M = 29.07$, $SD = 6.24$) showing slightly higher severity than urban participants ($M = 28.32$, $SD = 5.89$), suggesting potential cultural influences (Rakesh et al., 2021). Moreover, participants from joint families ($M = 29.39$, $SD = 5.73$) exhibited greater severity compared to those from nuclear families ($M = 27.77$, $SD = 6.54$), reinforcing evidence that shared familial stressors contribute to symptom persistence (Lima et al., 2023).

The duration of diagnosis showed no significant impact, with those diagnosed for less than a year ($M = 28.83$, $SD = 6.22$) and for 1-5 years ($M = 28.69$, $SD = 6.01$) displaying similar severity, suggesting that OCD remains stable over time (Stein et al., 2019). Psychiatric medication use also demonstrated minimal effects, with medicated individuals ($M = 28.71$, $SD = 6.30$) showing slightly lower severity than non-medicated ones ($M = 28.89$, $SD = 5.54$), supporting findings that pharmacological treatment alone may not substantially alter severity, particularly without behavioural interventions (Koolwal et al., 2022).

Obsessions were primarily contamination-related, followed by religious and sexual themes, while compulsions predominantly involved cleaning and checking behaviours, consistent with established OCD symptomatology patterns (Cervin, 2023; Stein et al., 2019). The presence of religious and sexual obsessions underscores the importance of culturally sensitive interventions, particularly in a diverse setting like India (Shafran et al., 1996; Rakesh et al., 2021). These findings highlight the need for targeted treatment approaches.

4.9 Discussion in Light of Hypotheses

4.9.1 Hypothesis 1: It is expected that there will be no sexual obsessions in adults with OCD.

The first objective was to study the presence of sexual obsessions in adults with OCD. To achieve this, descriptive statistical analysis, specifically frequency distribution, was conducted to assess the prevalence and characteristics of sexual obsessions among the study participants.

As it was hypothesised, the findings presented in Figure 4.2.1 illustrate the prevalence of sexual obsession among individuals with OCD, revealing that 31% of the sample experience sexual obsessions, either alone (13%) or in combination with religious obsessions (18%). This prevalence aligns with earlier research, which estimates that sexual obsessions affect approximately 16.8% to 30% of OCD patients (Kuty-Pachecka, 2021; Rasmussen & Tsuang, 1986). The majority (69%) do not exhibit these specific obsessions, indicating that OCD presents with diverse symptomatology. The presence of a substantial proportion of individuals suffering from sexual obsessions highlights the clinical importance of understanding and addressing these symptoms.

This aligns with previous findings that sexual obsessions can be misinterpreted as moral failings, leading to social withdrawal and self-stigmatization. Furthermore, the comorbidity of sexual and religious obsessions suggests that individuals with strong religious beliefs may experience heightened guilt and anxiety, further complicating their psychological well-being (Boger et al., 2020).

The link between childhood trauma and sexual obsessions in OCD has been well-documented, emphasising the need for comprehensive assessments that include early life experiences (Boger et al., 2020). Misdiagnosis remains a significant challenge, as sexual obsessions can be confused with paraphilic disorders, making accurate clinical differentiation essential (Vella-Zarb et al., 2017). These findings emphasise the substantial impact of sexual obsessions on mental health, consistent with literature linking these symptoms to heightened anxiety, depression, and impaired quality of life (Steinberg et al., 2016; Pozza et al., 2020). Freud's psychosexual theory suggests that unresolved conflicts during developmental stages, such as the anal or phallic stages, may manifest as obsessive-compulsive symptoms. For example, strict parental control during the anal stage may result in an anal-retentive personality, contributing to obsessive behaviours and heightened distress in adulthood (McLeod, 2019).

From a psychodynamic perspective, Freud's theories of psychosexual development provide a framework for understanding these findings. Fixation during the phallic stage, where sexual identity and relationships with parents are central, may result in the adoption of inappropriate defence mechanisms, leading to obsessive personality traits (Choudhary et al., 2022). Freud's beliefs about the id, ego, and superego provide insight into internal conflicts that might lead to unwanted sexual thoughts. The id represents fundamental needs, such as sexual and violent tendencies, which may conflict with the superego's moral beliefs (Choudhary et al., 2022). This conflict generates tension, which the ego attempts to reduce by engaging in obsessive-compulsive activities as a coping technique.

The findings reject Hypothesis 1, which proposed that "there will be no sexual obsessions in adults with OCD." The data indicate that a significant proportion of patients experience sexual obsessions, consistent with previous research by Kutty-Pachecka (2021) and Steinberg (2016), which highlights both the prevalence and distressing nature of these symptoms in individuals with OCD.

The findings highlight the significance of thorough clinical assessments and focused treatment strategies. The best treatment for sexual obsessions is still cognitive-behavioural therapy, especially exposure and response prevention; sexuality-focused therapy approaches are advised for this clinical population (Pozza et al., 2020). According to Koolwal et al. (2022), this strategy can be supplemented with pharmaceutical interventions, like selective serotonin reuptake inhibitors, to improve therapeutic results. Additionally, it is important to consider cultural and sociodemographic characteristics because they have a big impact on how symptoms manifest and how well treatments work (Surles, 2024).

In conclusion, sexual obsessions represent a significant and distressing aspect of OCD, affecting a notable proportion of patients. The study's findings contribute to the growing body of evidence on the clinical and demographic characteristics of sexual obsessions, highlighting the need for tailored interventions. From a psychodynamic perspective, unresolved conflicts during psychosexual development stages may contribute to these symptoms. Further research is warranted to explore the neurobiological, cultural, and treatment-related aspects of sexual obsessions in OCD (Mataix-Cols et al., 2022).

4.9.2 Hypothesis 2: It is expected that there will be no religious obsession in adults with OCD.

The second objective was to study the presence of religious obsession in adults with OCD. To achieve this, descriptive statistical analysis, specifically frequency distribution, was conducted to assess the study participants' prevalence and characteristics of religious obsessions.

As it was hypothesised, the findings presented in Figure 4.2.2 show that 38% of individuals with OCD experience religious obsessions, either alone (20%) or in combination with sexual obsessions (18%). This highlights the significant role of religious themes in OCD symptomatology. These findings are consistent with earlier studies demonstrating that religiosity might be a risk factor for OCD, especially in communities where religious beliefs heavily impact cognition and behaviour (Shafran et al., 1996; Rakesh et al., 2021). The majority of people (62%) do not have religious obsessions, suggesting that OCD has diverse symptoms.

The overlap between religious and sexual obsessions suggests a shared mechanism rooted in guilt, morality, and fear, which complicates treatment and symptom management (Witzig & Pollard, 2013; Shrivastava et al., 2022). Studies have shown that scrupulosity, characterized by pathological doubt and excessive religious rituals, is a distressing manifestation of OCD that often leads to delayed diagnosis and inadequate treatment due to shame and fear of divine punishment (Wu et al., 2018; Barman et al., 2023). Additionally, previous findings indicate that religious obsessions are associated with increased OCD severity, poorer treatment outcomes, and a higher risk of suicidality, further emphasising the need for culturally sensitive interventions (Buchholz et al., 2019; Nagy et al., 2020).

The findings of this study resonate with existing literature on religious obsessions in OCD. Miller (2007) described religious obsession as a condition marked by excessive guilt and preoccupation with moral or religious matters, leading to maladaptive behaviours. Witzig & Pollard (2013) further highlighted the role of pathological doubt and sin-related anxiety in scrupulosity. The influence of strong religious beliefs as a risk factor for OCD has been extensively documented (Shafran et al., 1996; Rakesh et al., 2021).

The Five-Factor Model of Personality (FFM), proposed by Costa and McCrae, provides a theoretical lens to understand personality traits associated with OCD, particularly religious obsessions. Neuroticism, one of the five factors, is characterised by emotional instability, anxiety, fear, and irritability (Cherry, 2023). Individuals with high neuroticism may exhibit

heightened concerns about moral values, repetitive praying, and excessive fear of sin, aligning with the symptomatology of religious OCD (Bilekli & Inozu, 2018). Additionally, conscientiousness, another FFM trait, reflects perfectionism and an intense need for order, traits commonly observed in individuals with OCD (Watson, 2012). These theoretical insights underscore the interplay between personality traits and the manifestation of religious obsessions, providing a deeper understanding of the disorder's aetiology.

The findings reject Hypothesis 2, which proposed that "there will be no religious obsessions in adults with OCD." The results indicate a significant prevalence of religious obsessions among patients, consistent with prior research by Sharma (2021) and Rakesh (2021). These findings emphasise the need to prioritise religious obsessions in the clinical management of OCD.

Clinicians must consider the unique characteristics of religious obsessions in OCD when designing treatment plans. Targeted interventions, such as cognitive therapy addressing belief domains (Siev et al., 2011) and strategies focusing on guilt and religiosity (Rakesh et al., 2021), are essential. Emerging therapies like Acceptance and Commitment Therapy (ACT) and the 4T Model show promise, particularly when culturally adapted (Dehaghi et al., 2024; Larmar et al., 2014). Given the high severity of symptoms, early diagnosis and comprehensive treatment—including pharmacological and behavioural therapies—are crucial for improving patient outcomes.

In conclusion, the results underscore the importance of specialist therapy techniques and tailored interventions due to the high frequency and severity of religious obsession. The study sheds light on the clinical features of people with religious obsessions in OCD. Given India's religious diversity, future research should concentrate on understanding how diverse religious beliefs impact OCD diagnosis and treatment results to develop successful, personalised therapy methods.

4.9.3 Hypothesis 3: It is expected that there will be no clinical correlates (anxiety and depression) in adults with OCD.

The third objective is to identify the clinical correlations (anxiety and depression) in adults with OCD. To achieve the third goal of determining the clinical correlates (anxiety and depression) in adults with OCD, Pearson's correlation coefficient was used to investigate the

relationships between anxiety, depression, and various dimensions of quality of life (QOL), such as physical health, psychological well-being, and social function.

As it was hypothesised, the findings from Table 4.3.1 and Figure 4.3.1 reveal a significant prevalence of anxiety and depression among individuals with OCD. With 99% of the sample exhibiting abnormal anxiety levels and 83% displaying abnormal depressive symptoms, these findings highlight the strong association between OCD and these comorbid conditions. This aligns with previous research indicating that anxiety and mood disorders are among the most common comorbidities in OCD patients (Sharma et al., 2021).

The extremely high prevalence of abnormal anxiety in the sample is consistent with findings that anxiety symptoms frequently exacerbate OCD severity, particularly in individuals with traits such as perfectionism (Lunn et al., 2023). Additionally, genetic studies have shown that first-degree relatives of individuals with pediatric-onset OCD are more prone to anxiety and mood disorders, further reinforcing the familial link in these comorbidities (Geller & Grossman, 2023).

Depression, similarly prominent in the sample, aligns with research showing that OCD patients often experience heightened depressive symptoms, particularly in those with obsessive thoughts related to mortality or existential concerns (Becker et al., 2023). Studies have also linked comorbid GAD to increased OCD symptom severity, anxiety, and avoidance behaviours (Sharma et al., 2021).

Furthermore, the relationship between OCD, sexual dysfunction, and depressed symptoms is well-documented, with research showing that depression has a major influence on OCD patients' quality of life (Ghassemzadeh et al., 2016). Emotional temperament, such as cyclothymic features, has also been demonstrated to worsen OCD symptoms and increase the risk of comorbid bipolar illness (D'Ambrosio et al., 2010). As well, sleep problems, which are frequent in OCD patients with comorbid depression, are known to impair treatment efficacy and increase relapse risk (Paterson et al., 2013). The correlation analysis reveals more about the relationship between anxiety, depression, and quality of life (QOL). A significant positive correlation ($r = .436$) was found between anxiety and depression, indicating that higher anxiety levels are associated with increased depression. This supports the diathesis-stress model, which posits that inherited vulnerabilities combined with stressors contribute to psychopathology (National Council of Education Research and Training, 2007). Both anxiety ($r = -.500$) and depression ($r = -.567$) negatively correlated with QOL, demonstrating their detrimental impact on overall well-being. These results align with Beck's cognitive theory of depression, which

highlights how negative cognitive schemas worsen depressive symptoms and impair individuals' perceptions of their world and future (Beck & Greenberg, 1984).

Additionally, physical and psychological health emerged as crucial factors influencing QOL. Physical health was positively correlated with QOL ($r = .740$) and negatively correlated with anxiety ($r = -.328$) and depression ($r = -.380$), suggesting that improved physical health mitigates these symptoms. Similarly, psychological health exhibited strong positive correlations with QOL ($r = .768$) and negative correlations with anxiety ($r = -.452$) and depression ($r = -.493$), underscoring its role in enhancing well-being. Social relationships ($r = .628$) and environmental factors ($r = .854$) also significantly contributed to QOL, highlighting the importance of supportive networks and favourable living conditions.

The results reject Hypothesis 3, which stated that "there will be no clinical correlates (anxiety and depression) in adults with OCD." The findings show that depression and anxiety are significant clinical variables affecting people with OCD (Sharma et al., 2021).

The findings are consistent with prior studies emphasising the prevalence and impact of anxiety and depression in OCD. For instance, Lunn et al. (2023) underscored the role of perfectionism in exacerbating anxiety disorders, while Geller & Grossman (2023) identified genetic studies which suggest that first-degree relatives of individuals with OCD often exhibit high rates of anxiety and mood disorders, highlighting the familial transmission of these comorbidities.

Becker et al. (2023) highlighted the distress caused by death anxiety and obsessive thoughts in OCD patients, which parallels the heightened anxiety and depression observed in individuals with sexual and religious obsessions in this study. Moreover, D'Ambrosio et al. (2010) emphasised the role of emotional temperament, such as cyclothymic temperament, in increasing the severity of OCD symptoms and comorbid bipolar disorder, further supporting the need to address psychological health in treatment strategies.

In conclusion, the study emphasises anxiety and depression, which are significant clinical correlates that profoundly impact the quality of life, physical health, and psychological well-being of OCD patients. These results underscore the need for a holistic approach to OCD treatment, focusing on reducing anxiety and depression while enhancing overall health, social support, and environmental factors. By aligning with previous research and theoretical

frameworks, this study reinforces the complexity of OCD and highlights the importance of personalised treatment strategies.

4.9.4 Hypothesis 4: It is expected that there will be no mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession.

The fourth objective was to examine the mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsessions and OCD severity. A structural equation model (SEM) approach was employed to achieve this. The analysis was conducted using AMOS (version 23) software to test for the mediation effects of anxiety and depression, enabling a comprehensive understanding of their role in this relationship.

The results in Table 4.4.1 and Figure 4.4.1 demonstrate a well-fitting model. The non-significant Chi-square value (78.425, $df = 100$, $p = 0.946$) indicates that the model closely aligns with the observed data. The low CMIN/DF ratio (0.784) further supports this conclusion, while the fit indices (GFI = 0.917, AGFI = 0.873, CFI = 1.000) reflect a good to excellent model fit. Moreover, the RMSEA value (0.000) confirms minimal error, underscoring the model's strength in accurately capturing the data structure.

As it was hypothesised, the findings presented in Table 4.4.2 revealed that while OCD significantly predicted both anxiety and depression, religious obsessions uniquely predicted depression, whereas sexual obsessions did not show a significant relationship with either anxiety or depression. These findings align with previous literature suggesting that religious obsessions, particularly scrupulosity, are associated with heightened guilt, self-reproach, and moral anxiety, which contribute to depressive symptoms (Shafran et al., 1996; Rakesh et al., 2021). Conversely, sexual obsessions, despite being distressing, may be more closely related to shame and identity concerns rather than classical anxiety or depressive symptoms (Abramowitz et al., 2025). This suggests that their emotional burden may manifest through self-doubt, interpersonal distress, or avoidance behaviours rather than diagnosable mood symptoms (Williams et al., 2011).

The diathesis-stress model provides a theoretical explanation for these findings, suggesting that individuals with a biological predisposition (diathesis) are more likely to develop OCD when exposed to stressors, such as moral conflicts (religious obsessions) or sexual identity concerns

(sexual obsessions) (National Council of Education Research and Training, 2007). However, religious obsessions may serve as a more potent pathogenic stressor, exacerbating vulnerability to depression due to the internalized guilt and fear of divine punishment often observed in scrupulosity (Witzig & Pollard, 2013). In contrast, the emotional distress caused by sexual obsessions may be shaped more by external cultural taboos and personal shame (Nicolini et al., 2017), potentially leading to avoidance behaviours rather than direct emotional dysregulation (Abramowitz & Jacoby, 2014). This distinction highlights the differential psychological burden of these obsession types.

Beck's cognitive theory of depression further supports the association between religious obsessions and depression, as individuals with scrupulosity may develop negative schemas about themselves, the world, and the future, reinforcing cognitive biases and maladaptive thought patterns (Beck & Greenberg, 1984). These biases may lead to persistent negative appraisals of one's moral worth, contributing to the maintenance of depressive symptoms (Kring et al., 2012). Additionally, previous studies suggest that individuals with religious OCD symptoms are particularly prone to cognitive distortions and excessive responsibility, which may further increase vulnerability to depression (Siev et al., 2011).

Findings from Table 4.4.3 show that the mediation analysis further elucidated these relationships, demonstrating that depression significantly mediated the link between religious obsessions and OCD severity ($\beta = 0.127$, $p < 0.05$), while anxiety did not serve as a mediator for either sexual or religious obsessions. Specifically, religious obsessions had a moderate and significant indirect effect on OCD severity through depression ($\beta = 0.127$), whereas the indirect effect of religious obsessions via anxiety was small and non-significant ($\beta = 0.0043$). Similarly, neither anxiety nor depression mediated the relationship between sexual obsessions and OCD severity. The indirect effect of sexual obsessions on OCD severity via depression was small, negative, and non-significant ($\beta = -0.0988$), and via anxiety, it was also non-significant ($\beta = -0.0519$). The non-significant results for sexual obsessions suggest that distress arising from such obsessions may be more closely tied to interpersonal concerns, cultural stigma, or identity conflicts rather than clinical anxiety or depressive symptoms (Williams, Farris, et al., 2011).

These findings partially supported Hypothesis 4, which posited that clinical correlates (anxiety and depression) would not mediate the relationship between obsession types and OCD severity. While anxiety did not mediate either obsession type, depression significantly mediated the relationship between religious obsessions and OCD severity, suggesting that

depressive symptoms play a crucial role in the impact of religious obsessions on OCD. Therefore, Hypothesis 4 is rejected for depression but supported for anxiety.

Clinically, these results suggest that addressing depressive symptoms may be particularly important in the treatment of scrupulosity. Prior studies indicate that cognitive therapy targeting obsessive beliefs and guilt-related thoughts can improve treatment outcomes for individuals with religious obsessions (Siev et al., 2011). Additionally, exposure-response prevention (ERP) combined with cognitive techniques, such as thought-stopping, is effective in reducing the severity of religious obsessions (Sinha & Chakrabarti, 2022). However, given that sexual obsessions did not significantly predict anxiety or depression, ERP-based interventions may need to be adapted for these individuals, possibly by incorporating strategies to address shame, self-identity concerns, and cultural stigma.

The findings also contribute to the broader literature on OCD comorbidities, reinforcing evidence that OCD frequently coexists with anxiety and mood disorders (Sharma et al., 2021; Geller & Grossman, 2023). Comorbid depression has been shown to exacerbate OCD severity, particularly in cases involving religious obsessions (Becker et al., 2023). Research further indicates that anxiety-driven avoidance behaviours may perpetuate OCD symptoms (Torres et al., 2019). Moreover, the present study supports previous findings that religious obsessions are closely tied to suicidality due to heightened guilt and moral distress (Nagy et al., 2020).

In conclusion, this study highlights the differential impact of sexual and religious obsessions on OCD severity. Religious obsessions strongly predict depressive symptoms, which in turn mediate their effect on OCD severity. Conversely, sexual obsessions, while distressing, do not significantly predict anxiety or depression, suggesting that their psychological burden may manifest in alternative ways, such as shame or identity distress. These findings underscore the importance of addressing depressive symptoms, particularly in individuals with religious obsessions, and suggest that targeted interventions such as cognitive therapy and ERP may be beneficial in mitigating the psychological burden of scrupulosity. Future research should explore cultural influences on the expression of distress in sexual obsessions and develop tailored interventions for individuals experiencing distress due to these symptoms.

4.9.5 Hypothesis 5: It is expected that there will be no moderating effects on the quality of life of people with sexual and religious obsessions in OCD.

The fifth objective was to examine the moderating effect of Quality of Life (QOL) in the relationship between sexual obsessions (SO), religious obsessions (RO) and OCD severity. A structural equation model (SEM) approach was employed to achieve this. The analysis was conducted using AMOS (version 23) software to test for the moderation effects of QOL, enabling a comprehensive understanding of its role in this relationship.

As hypothesised, the findings presented in Table 4.5.1 provide insight into the moderating role of Quality of Life (QOL) in the relationship between Religious Obsessions (RO), sexual obsessions (SO), and OCD severity.

The moderation analysis revealed that QOL significantly impacts the relationship between RO and OCD severity. Specifically, the interaction term for religious obsessions and quality of life (InterRO_QOL) was significant ($\beta = -0.350$, $p = .008$), indicating that individuals with higher QOL exhibited a sharper decline in OCD symptoms as religious obsessions increased. This finding suggests that higher QOL may serve as a protective factor, buffering against the negative impact of religious obsessions on OCD severity. One possible explanation is that individuals with higher QOL may have greater access to coping mechanisms such as social support, spiritual coping, and cognitive reframing, which mitigate the distress associated with religious obsessions (Gordon, 2002). This aligns with the PERMA model of well-being (Seligman, 2012), which emphasises the role of positive emotions, engagement, relationships, meaning, and accomplishments in enhancing mental health. Higher QOL may foster resilience and adaptive coping, reducing the severity of OCD symptoms linked to religious obsessions. Furthermore, Maslow's Hierarchy of Needs (1943) supports this interpretation by suggesting that individuals who have fulfilled lower-level needs (e.g., safety and social belonging) may be better equipped to manage stressors such as religious obsessions. Higher QOL, which encompasses life satisfaction and well-being, likely facilitates cognitive flexibility and emotional stability, allowing individuals to reinterpret their religious thoughts in less distressing ways.

Unlike religious obsessions, the moderation analysis did not find a significant interaction between SO and QOL in predicting OCD severity. The interaction between sexual obsessions and quality of life (InterSO_QOL) was not significant ($\beta = 0.084$, $p = .524$), suggesting that the impact of sexual obsessions on OCD remains stable, regardless of an individual's QOL.

Interestingly, individuals with higher QOL reported greater OCD severity at both low and high levels of SO, indicating that QOL does not buffer against the distress caused by sexual obsessions. One possible explanation is that sexual obsessions are often associated with heightened feelings of shame, guilt, and internal conflict, which persist despite overall well-being (Boger et al., 2020). Unlike religious obsessions, which may be alleviated through spiritual coping and social support, sexual obsessions are more stigmatised, and it is difficult to discuss openly, contributing to sustained OCD severity (Gordon, 2002).

These results align with previous research showing that sexual obsessions are more frustrating because of social and cultural taboos (Siev et al., 2011). For OCD patients, especially those with unpleasant sexual and religious obsessions, cognitive therapy that targets obsessive thoughts has been shown to enhance therapeutic outcomes (Siev et al., 2011). However, the persistence of high OCD severity among individuals with greater QOL suggests that interventions should specifically address the unique distress caused by sexual obsessions. The stigma surrounding sexual obsessions may prevent individuals from seeking appropriate support or treatment, reinforcing their impact on OCD severity.

The covariance and correlation analysis from Table 4.5.2 further reinforces the distinct roles of QOL in moderating religious and sexual obsessions. The significant negative association between InterSO_QOL and SO indicates that as sexual obsessions increase, their interaction effect with QOL decreases. This suggests that QOL plays a lesser role in alleviating distress associated with sexual obsessions compared to religious obsessions. Additionally, the analysis reveals a significant positive relationship between religious obsessions and sexual obsessions, implying that individuals experiencing religious obsessions are also likely to experience sexual obsessions. This finding aligns with previous research indicating that religious and sexual obsessions often co-occur due to underlying cognitive distortions related to morality, guilt, and control (Garg et al., 2023).

The study's findings align with the PERMA model (Seligman, 2012), which emphasises the importance of positive psychological factors in enhancing well-being. While high quality of life (QOL) appears to mitigate the effects of religious obsessions on OCD severity, it does not provide the same protective effect for sexual obsessions. This suggests that well-being interventions should be tailored to the specific types of obsessions experienced by individuals with OCD. For religious obsessions, fostering meaning, engagement, and social connections

may be beneficial (Seligman, 2012), whereas for sexual obsessions, cognitive restructuring and stigma reduction strategies may be more effective (Boger et al., 2020; Siev et al., 2011).

Additionally, Maslow's Hierarchy of Needs (Maslow, 1943) supports the notion that fulfilling higher-level psychological needs contributes to improved QOL and mental health outcomes. Individuals with high QOL may experience greater emotional resilience, allowing them to reinterpret religious obsessions in a less distressing manner (Gordon, 2002). However, the persistence of sexual obsessions despite high QOL underscores the need for targeted therapeutic interventions that address the shame and stigma associated with these obsessions (Garg et al., 2023).

These findings partially supported Hypothesis 5, which posited that quality of life (QOL) does not moderate the relationship between religious and sexual obsessions in OCD. The results indicate that while QOL significantly moderates the relationship between religious obsessions and OCD severity, it does not moderate sexual obsessions. Therefore, Hypothesis 5 is rejected for religious obsessions but supported for sexual obsessions in OCD.

The results of this study highlight the importance of addressing QOL factors in the treatment of OCD. While general well-being interventions may be beneficial for individuals with religious obsessions, those with sexual obsessions may require more specialised cognitive-behavioural strategies to manage distress (Carboneau, 2018). Future research should explore additional factors that may moderate the relationship between sexual obsessions and OCD severity, such as cultural attitudes, self-compassion, and emotion regulation strategies (Mcintosh, 2017). Moreover, integrating positive psychology approaches, such as the PERMA model, into OCD treatment plans may enhance treatment outcomes by improving overall well-being (Seligman, 2011). Addressing stigma and fostering open discussions about sexual obsessions may also help individuals seek appropriate support and reduce the distress associated with these obsessions.

Overall, the findings suggest that QOL plays a partial moderating role in OCD, significantly influencing the relationship between religious obsessions and OCD severity but not sexual obsessions. This partially supports the research hypothesis, as QOL does not moderate the effects of sexual obsessions but does influence religious obsessions. The results indicate that individuals with religious obsessions may experience a reduction in OCD severity when they have a higher QOL, suggesting that improving overall well-being can help alleviate the distress

associated with religious obsessions. In contrast, the severity of sexual obsessions remains high regardless of QOL, highlighting the need for more intensive therapeutic interventions. Since sexual obsessions persist irrespective of an individual's well-being, targeted cognitive-behavioural and stigma-reducing therapies are crucial in managing their impact. Moreover, the positive relationship between religious and sexual obsessions implies that individuals experiencing religious obsessions are also likely to experience sexual obsessions. Given this co-occurrence, it is essential to monitor both obsessions over time to ensure effective intervention and prevent worsening symptoms. These findings emphasise the complex relationship between QOL and OCD, underscoring the need for tailored treatment approaches that address the distinct distress caused by different types of obsessions.

4.9.6 Hypothesis 6: It is expected that there will be no significant difference in the adults having a sexual and religious obsession with OCD in relation to Gender.

The sixth objective was to examine gender differences in the prevalence of sexual and religious obsessions in individuals with OCD. A chi-square test for independence was employed to assess the association between gender and the presence of these obsessional themes.

As hypothesised, the findings presented in Table 4.6.3 and Table 4.6.4 indicate no statistically significant gender differences in the distribution of sexual and religious obsessions among individuals with OCD. Although some variations in frequency distribution were noted, the chi-square test results confirmed that these differences were not statistically significant. This finding is consistent with previous research, which reports inconsistent evidence regarding gender differences in OCD symptomatology (Barman et al., 2023).

Gender Differences in Sexual Obsessions

The frequency distribution analysis revealed that males exhibited a slightly higher prevalence of sexual obsessions, either alone or in combination with religious obsessions, compared to females. Specifically, 12 males reported both sexual and religious obsessions, compared to 6 females. Additionally, 8 males reported sexual obsessions only, while 5 females reported the same. Conversely, a greater proportion of females (41) were categorised as having OCD without sexual obsessions, compared to 28 males. However, chi-square test results ($p = .083$) indicated that these differences were not statistically significant, suggesting that gender-based differences in sexual obsessions may be attributable to chance.

Existing literature presents mixed findings regarding gender differences in sexual obsessions. Some studies report that males are more likely to experience sexual obsessions involving taboo or aggressive themes, such as fears of sexual orientation or intrusive sexual thoughts (Kuty-Pachecka, 2021; Rasmussen & Tsuang, 1986). Sociocultural factors, including gender norms and differences in sexual expression, may contribute to the higher prevalence of sexual obsessions in males. Conversely, females may underreport sexual obsessions due to greater stigma and associated distress (Abbey et al., 2007). Studies also suggest that sexual obsessions are frequently misdiagnosed as paraphilias or other sexual disorders, particularly in males (Vella-Zarb et al., 2017). Nevertheless, other studies report no significant gender differences in sexual obsessions, emphasising that while content may vary, prevalence rates remain comparable (Steinberg et al., 2016).

Gender Differences in Religious Obsessions

Analysis of religious obsessions revealed some differences in frequency distribution between genders. Females exhibited a higher prevalence of religious obsessions alone (13 females vs. 7 males), whereas males were more likely to experience both sexual and religious obsessions (12 males vs. 6 females). However, as with sexual obsessions, these differences were not statistically significant ($p = .142$), indicating no meaningful association between gender and religious obsessions.

Previous studies suggest that females are more prone to scrupulosity-related symptoms, such as excessive guilt, heightened moral concerns, and fears of sinning, potentially due to stronger internalised moral and ethical values (Witzig & Pollard, 2013). Research conducted by Rakesh et al. (2021) also highlights that individuals from religious backgrounds, particularly women, may be more vulnerable to developing religious obsessions. On the other hand, males with religious obsessions are more likely to experience intrusive blasphemous thoughts or aggressive religious imagery, which can lead to heightened distress and functional impairment (Shrivastava et al., 2022).

Scrupulosity, a subtype of OCD involving religious obsessions, has been linked to excessive guilt, moral rigidity, and fear of divine punishment. Studies indicate that religious individuals often display greater anxiety about violating moral standards, contributing to the persistence of religious obsessions (Shafran et al., 1996; Buchholz et al., 2019). In India, where religiosity is deeply embedded in social and cultural frameworks, religious obsessions are particularly common (Rakesh et al., 2021). Cultural norms may also influence symptom-reporting patterns, as stigma around sexual obsessions may lead to underreporting, particularly among females

(Abbey et al., 2007). Conversely, heightened emphasis on moral conduct in certain cultural contexts may increase the expression of religious obsessions, especially in women (Witzig & Pollard, 2013; Rakesh et al., 2021). However, the lack of significant gender differences in this study shows that although the contents of religious obsessions may vary between men and women, their overall prevalence is similar.

These findings fail to reject Hypothesis 6, which posited that there are no significant gender differences in the prevalence of sexual and religious obsessions among adults with OCD. The results indicate no statistically significant gender differences in the distribution of these obsessions, aligning with previous research suggesting that while gender-based variations in OCD symptomatology exist, they may not always reach statistical significance (Barman et al., 2023).

These results are also consistent with the broader literature on OCD, which highlights the complex interplay of cultural, psychological, and environmental factors in shaping obsessional content (Gordon, 2002). The absence of significant gender differences in this study underscores the need for further research into potential moderators, such as cultural values, personality traits, and trauma history, which may better explain variation in obsessional themes (Boger et al., 2020; Wu et al., 2018).

These findings have significant implications for clinical practice and future studies. Individualised therapies that focus on the nature and intensity of obsessions rather than presuming gender-based patterns should be given priority in treatment methods for OCD, as there are no observable gender differences. Cognitive-behavioural treatment, including exposure and response prevention, is still the gold standard for treating sexual and religious obsessions in OCD (Koolwal et al., 2022).

Future research should explore how sociocultural factors influence the presentation and severity of obsessional content, as gender differences may be more pronounced in specific cultural contexts (Sharma et al., 2021).

Since previous studies indicate that sexual and religious obsessions are often linked to heightened distress and functional impairment (Pozza et al., 2020), clinicians should be mindful of potential underreporting, particularly among female patients. Addressing stigma and fostering a supportive therapeutic environment may improve symptom disclosure and treatment outcomes.

In conclusion, the present study found no significant gender differences in the prevalence of sexual and religious obsessions among individuals with OCD. Although some variations in frequency distribution were observed, these differences were not statistically significant, indicating that gender may not play a significant role in determining obsessional content. These findings align with previous research indicating that gender-based patterns in OCD symptomatology may exist but are often not significant. Future research should explore additional moderating variables, such as cultural background, religious upbringing, and psychological traits, to further clarify the factors influencing obsessional content across genders.

4.9.7 Hypothesis 7: It is expected that there will be no significant difference in the quality of life of people suffering from sexual and religious obsessions with OCD.

The seventh objective was to analyse the quality of life (QOL) of individuals with Obsessive-Compulsive Disorder (OCD), particularly those with sexual and religious obsessions. To achieve this, descriptive statistics (frequency distribution) were conducted to summarise QOL data, and an ANOVA test was used to analyse the mean differences in QOL between groups of individuals with OCD and post hoc tests were required to identify the specific groups that differ significantly (McHugh, 2011).

As it was hypothesised, the findings from Table 4.7.1, the QOL distribution among individuals with OCD, reveal that none of the participants reported a high QOL, illustrating the significant impact of OCD on overall well-being regardless of obsession type. Notably, patients with sexual obsessions (53.8%) and those with both sexual and religious obsessions (50%) show the highest proportion of low QOL scores. This suggests that sexual obsession, whether alone or combined with religious obsessions, is associated with greater distress and impairment. Patients with religious obsessions alone show a comparatively better QOL profile. These findings align with Pozza et al. (2020), who reported that sexual obsessions are linked to higher distress, social dysfunction, and interpersonal difficulties.

The findings in Table 4.7.2 highlight the significant impact of OCD on various domains of quality of life (QOL); the data highlight that individuals with sexual obsessions exhibit the highest rates of impairment across physical health (84.6%), psychological health (53.8%), and social relationships (92.3%). Consistent with Garg et al. (2023), this suggests that sexual

obsessions contribute significantly to psychosocial dysfunction, heightened distress, and social avoidance. Patients with religious obsessions alone demonstrate comparatively better outcomes, reinforcing findings by Singh et al. (2022), who noted that religious obsessions, though distressing, may induce less impairment than sexual obsessions. Environmental QoL remains relatively stable across subgroups, aligning with Morgieva et al. (2016), who noted that environmental factors are less susceptible to OCD symptom variation.

The findings in Table 4.7.3 indicate that the mean QOL score of 65.09 with a standard deviation of 8.50 suggests that OCD patients generally experience impaired quality of life. The mild negative skew (-0.412) and slightly flattened distribution (-0.633) indicate a broader spread of scores, consistent with previous research that highlights significant variability in QOL outcomes across OCD subtypes (Stein et al., 2019). The findings from Table 4.7.4 revealed a non-significant result ($p = 0.063$) from Levene's test, confirming that variance across groups is homogeneous, meeting the assumption for ANOVA testing (Kim, 2014). Table 4.7.4 reveals that individuals with OCD without sexual and religious obsessions reported the highest QOL ($M = 67.25$), while those with sexual obsessions had the lowest QOL ($M = 58.92$). This aligns with Żerdziński et al. (2022), who highlighted that sexual obsessions are particularly distressing and linked to shame, guilt, and social stigma, factors known to worsen QOL.

The ANOVA results from Table 4.7.6 reveal a significant difference in QOL scores among OCD subgroups ($p = 0.009$). This finding corroborates research by Belli et al. (2024), who identified sexual obsessions as having a profound negative impact on well-being. Further post hoc analysis was necessary to identify specific group differences. The ANOVA and post hoc results from Table 4.7.7 collectively demonstrate that OCD patients with sexual obsessions experience significantly poorer QOL compared to those without sexual and religious obsessions ($p = 0.008$). This confirms the heightened distress associated with sexual obsessions. Other subgroup differences, while notable, were not statistically significant. This finding aligns with trends observed in Remmerswaal et al. (2016), where sexual obsessions were shown to have a greater detrimental influence on quality of life than religious obsessions.

The findings can be interpreted through Maslow's Hierarchy of Needs (Maslow, 1943; Cherry, 2022) and the PERMA Model of Well-being (Seligman, 2012). According to Maslow, individuals with OCD experiencing distressing obsessions may struggle to fulfil lower-level needs, such as physiological needs (e.g., sleep, nutrition) and safety needs (e.g., mental

security, stability). Patients with severe sexual obsessions, marked by guilt and shame, may experience disruptions at the social needs level, impacting relationships and acceptance. The negative self-image characteristic of those with sexual obsessions likely interferes with self-esteem needs, further impairing their QOL. In contrast, the PERMA model emphasises well-being through Positive Emotion, Engagement, Relationships, Meaning, and Achievement (Seligman, 2012). Individuals with sexual obsessions may experience reduced positive emotions, social withdrawal, and diminished feelings of achievement due to heightened anxiety and intrusive thoughts. Targeted interventions that foster positive relationships, strengthen social bonds, and encourage meaningful engagement may enhance quality of life (QOL) outcomes.

The findings reject Hypothesis 7, which proposed that there would be no significant difference in the quality of life of individuals with OCD experiencing sexual and religious obsessions. Instead, the results indicate a statistically significant difference (Belli et al., 2024).

These findings underscore the need for tailored interventions targeting the unique distress associated with sexual and religious obsessions. Cognitive Behavioural Therapy (CBT), which focuses on reducing guilt and cognitive distortions and enhancing coping mechanisms, may offer beneficial outcomes for these subgroups. Additionally, interventions aimed at improving social relationships and reducing stigma are crucial in strengthening overall QOL in individuals with OCD (Żerdziński et al., 2022). Furthermore, sexuality-focused therapy techniques should be incorporated to address specific distress related to sexual obsessions and improve overall well-being (Pozza et al., 2020).

In conclusion, the findings underscore that OCD patients with sexual obsessions experience significantly poorer QOL compared to those without such obsessions. Religious obsessions have a comparatively moderate impact, with individuals experiencing both obsession types showing a notable, though less severe, QOL impairment. These outcomes align with broader literature emphasising that sexual obsessions are particularly distressing and linked to significant social, psychological, and physical impairment. Targeted interventions addressing the unique distress associated with sexual and religious obsessions are crucial to improving QOL outcomes in this population. Sexuality-focused therapy techniques and integrating approaches from Maslow's hierarchy and the PERMA model may provide a comprehensive framework for improving QOL in these patients.

CHAPTER - V

SUMMARY

AND

CONCLUSION

CHAPTER - V

SUMMARY AND CONCLUSION

This summary gives an overview of the complete study, highlighting the main findings from each chapter. It summarises the fundamental principles, methods, findings, and research implications.

- **Summary of Previous Chapters:** This section recaps key content from Chapter 1 (Introduction, Theoretical and Conceptual Frameworks), Chapter 2 (Review of Literature, Objectives, and Hypotheses), and Chapter 3 (Research Methodology), providing context for the study.
- **Summary of Major Findings:** Highlights the principal results, particularly regarding the prevalence, clinical correlates, and impact of sexual and religious obsessions on quality of life in OCD.
- **Conclusion:** Synthesises the study's overall findings, linking them back to the research objectives and hypotheses.
- **Implications:** Offers recommendations based on the findings, with a focus on clinical practice, public health initiatives, and policy development.
- **Strengths and Limitations:** Discusses the study's contributions and acknowledges methodological limitations affecting generalisability.
- **Future Directions:** Identifies areas for future research to improve understanding and treatment of OCD, particularly in relation to sexual and religious obsessions.

Chapter 1: Introduction

Obsessive-Compulsive Disorder (OCD) is a chronic psychiatric condition characterised by intrusive obsessions and compulsions that cause significant distress and impair daily functioning (Behera, 2013; American Psychiatric Association, 2013). While previously classified under anxiety disorders, OCD is now recognised as part of the obsessive-compulsive and related disorders category in DSM-5 (Ferguson, 2023). Despite this reclassification, severe anxiety remains central to the disorder, often driving compulsive rituals aimed at reducing distress (Kelly, 2019).

Globally, OCD ranks among the top ten most disabling disorders, typically emerging around 19.5 years of age (World Health Organisation, 2001). Men are more likely to develop OCD earlier and with tic disorders, while women have a higher overall prevalence (Ruscio et al., 2010; Bayırlı, 2013). The disorder has high comorbidity with anxiety, mood disorders, and obsessive-compulsive spectrum disorders, including compulsive sexual behaviour disorder (Fuss et al., 2019; Toprak, 2024).

OCD is diagnosed based on persistent, intrusive thoughts and compulsive behaviours (American Psychiatric Association, 2013). The ICD-10 classifies it into obsessive thoughts, compulsive behaviours, and mixed presentations (Modi, 2016), while the ICD-11 refines criteria to better capture the obsession-compulsion relationship (World Health Organisation, 2011). Historically, OCD has been linked to religious scrupulosity, with early theological descriptions of obsessive fears of sin (OCD-UK, 2018). Modern treatment includes cognitive behavioural therapy (CBT), particularly exposure and response prevention (ERP), and pharmacotherapy (Steketee et al., 2011; Williams et al., 2011).

Theoretical and Conceptual Frameworks

OCD can be explained through various theories. The interactionist model examines genetic predisposition and environmental triggers (Scarr & McCartney, 1983) while labelling theory highlights the impact of stigma on self-perception (Becker, 1963). The biological model attributes OCD to dysfunctions in the orbitofrontal cortex and basal ganglia (Huey et al., 2008; Modi, 2016). Cognitive-behavioural models suggest compulsions develop to neutralise intrusive thoughts (Salkovskis et al., 1998), while psychodynamic theories link OCD to unconscious conflicts (Choudhary et al., 2022). The five-factor model associates OCD with high neuroticism and conscientiousness (Costa & McCrae, 1992), and the diathesis-stress model considers genetic vulnerability and environmental stress (National Council of Education Research and Training, 2007). Beck's cognitive theory connects OCD with depression through negative schemas (Beck & Greenberg, 1984).

Maslow's hierarchy of needs and Seligman's PERMA model provide insights into the quality of life (QOL) in OCD. Maslow's theory highlights the need to fulfil basic physiological and psychological needs (Sirgy, 1986), while the PERMA model emphasises positive emotions, engagement, relationships, meaning, and accomplishments for mental well-being (Seligman, 2012). Addressing these factors in treatment can improve resilience and self-worth (Forgeard et al., 2011).

Sexual and Religious Obsessions in OCD

OCD manifests in various forms, including distressing sexual and religious obsessions. Sexual obsessions involve intrusive, inappropriate sexual thoughts that cause anxiety and shame, despite no actual desire to act on them (Kuty-Pachecka, 2021; Hart, 2020). Religious obsessions, or scrupulosity, involve excessive fears of committing immoral acts or divine punishment, leading to compulsive religious rituals (Rosen, 2014; Deibler, 2022). Scrupulosity is particularly prevalent in highly religious individuals, with up to 33% of OCD patients experiencing religious obsessions (Rakesh et al., 2021). Religiosity, whether intrinsic (faith-driven) or extrinsic (goal-oriented), can influence obsessive behaviours, especially in rigid religious cultures (Allport & Ross, 1967; Kazmi, 2019; Bilekli & Inozu, 2018).

Comorbidities and Impact on Quality of Life

Anxiety and depression commonly co-occur with OCD. Anxiety disorders involve excessive worry and physical symptoms, whereas OCD includes compulsions to manage distress (American Psychological Association, 2022; Catchings, 2024). OCD is also associated with serotonin imbalance (Catchings, 2024). Depression, characterised by persistent depression and loss of interest, worsens OCD symptoms (Sawchuk, 2022; OCD UK, 2013). Both illnesses are frequently treated with cognitive behavioural therapy and medications (OCD UK, 2013). OCD lowers QOL, making everyday tasks difficult and raising emotional suffering (Teoli & Bhardwaj, 2022; OCD UK, 2018a). Many patients externally maintain routines while struggling internally, suggesting focusing on the need for accurate treatment methods (Macy et al., 2013).

Chapter 2: Review of Literature

Obsessive-Compulsive Disorder (OCD) is a chronic neuropsychiatric condition characterised by intrusive obsessions and compulsions, affecting 1–3% of the population and leading to significant impairment if untreated (Cervin, 2023; Stein et al., 2019). Research highlights the complex interplay between OCD, sociodemographic factors, comorbidities, and quality of life (QOL).

Sexual and religious obsessions are common in OCD. Sexual obsessions contribute to heightened anxiety, depression, and relationship dysfunction (Steinberg et al., 2016; Abbey et al., 2007). Religious obsessions, or scrupulosity, involve excessive guilt, pathological doubt, and moral preoccupation, with strong religious beliefs often exacerbating symptom severity,

especially in non-Western societies (Witzig & Pollard, 2013; Shafran et al., 1996; Rakesh et al., 2021).

OCD frequently coexists with depression, anxiety, and personality disorders, with genetic and familial factors playing a crucial role in its development (Lima et al., 2023; Geller & Grossman, 2023). The disorder is also associated with sexual dysfunction, sleep disturbances, and heightened death anxiety, contributing to reduced well-being (Pozza et al., 2020; Becker et al., 2023). Impaired QOL in OCD results from symptom severity, stigma, and poor insight, affecting relationships, marital satisfaction, and overall life satisfaction (Belli et al., 2024; Garg et al., 2023).

While cognitive behavioural therapy (CBT) and selective serotonin reuptake inhibitors (SSRIs) are effective, many individuals continue to experience diminished QOL (Morgieve et al., 2016; Koolwal et al., 2022). Given the intricate relationship between OCD, comorbidities, and QOL, further research is essential to develop targeted interventions that address both core symptoms and psychosocial challenges (Żerdziński et al., 2022; Siev et al., 2011). This review explores treatment approaches for OCD, focusing on cognitive, behavioural, and pharmacological interventions. While CBT, especially ERP, is effective, managing religious and sexual obsessions remains challenging (Toprak, 2024; Williams et al., 2011). Innovative therapies like ACT and the 4T Model show potential (Dehaghi et al., 2024; Larmar et al., 2014). Treatment outcomes are influenced by insight, comorbidities, and neurobiological factors (Mataix-Cols et al., 2022; Reimer et al., 2018). Future studies should investigate long-term effectiveness, cultural adaptations, and stigma reduction (Steketee et al., 2011; Pallanti et al., 2011).

Objectives:

1. To study sexual obsession in adults with OCD.
2. To identify religious obsession in adults with OCD.
3. To determine the clinical correlates (anxiety and depression) in adults with OCD.
4. To find the mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession with OCD.
5. To find the moderating effects of quality of life on people with sexual and religious obsessions in OCD.
6. To examine the gender differences in adults having a sexual and religious obsession with OCD.

7. To analyse the quality of life of people suffering from sexual and religious obsessions in OCD.

Hypothesis: (Null hypothesis)

Ho 1. There will be no sexual obsessions in adults with OCD.

Ho 2. There will be no religious obsession in adults with OCD.

Ho 3. There will be no clinical correlates (anxiety and depression) in adults with OCD.

Ho 4. There will be no mediating effect of clinical correlates (anxiety and depression) in the relationship between sexual and religious obsession.

Ho 5. There will be no moderating effects on the quality of life of people with sexual and religious obsessions in OCD.

Ho 6. There will be no significant difference in adults having a sexual and religious obsession with OCD in relation to Gender.

Ho 7. There will be no significant difference in the quality of life of people suffering from sexual and religious obsessions with OCD.

Chapter 3: Research Methodology

Research Design

This study uses a cross-sectional research methodology to investigate sexual obsession, religious obsessions, clinical correlates, and quality of life in people with Obsessive-Compulsive Disorder (OCD). A deductive method is applied, progressing from general theories to specific hypotheses. Data collection involves primary and secondary sources through standardised psychological instruments (Goodman et al., 1989; Zigmond & Snaith, 1997; WHOQOL Group, 1997).

Sampling Design and Sample Size

A purposive sampling technique was used to select 100 patients diagnosed with OCD, based on DSM-5 (APA, 2013) or ICD-10 (WHO, 1992) criteria, from Ashoka Neuro Psychiatric Hospital & Addiction Centre, Jalandhar, Punjab. Participants, aged 18 to 40 years, were recruited from both outpatient (OPD) and inpatient (IPD) departments. To ensure rapport-building, an interview method was employed (Reddy et al., 2010; Jaisoorya et al., 2017).

Sample Size Justification

A sample size of 100 was chosen based on OCD's low prevalence in India (0.6%-0.8%; Reddy et al., 2010; Jaisoorya et al., 2017) and power analysis (95% confidence level, 80% power, medium effect size) recommending at least 87 participants (Cherian et al., 2014). Previous studies (Devi et al., 2023; Garg et al., 2023) support this choice, and smaller sample feasibility is validated in healthcare research (Schwarzkopf & Huang, 2023).

Criteria for Sample Selection

Inclusion Criteria:

- People aged 18–40 years
- Primary diagnosis of OCD (DSM-5 or ICD-10).
- Patients from the psychiatric OPD and IPD.
- Both male and female participants.
- Minimum education level of upper primary.
- Able to be interviewed in person with the help of a Mini-Mental State Examination (MMSE).

Exclusion Criteria:

- Individuals below 18 years.
- Participants with lower educational levels or illiterate individuals.
- Presence of organic mental illness.
- Inability to understand and provide informed consent.

Research Instruments

Yale-Brown Obsessive-Compulsive Disorder Scale (Y-BOCS)

A 10-item clinician-rated scale that assesses obsession and compulsion severity (Goodman et al., 1989). Scores range from 0 to 40, with higher scores indicating greater symptom severity. Cronbach's alpha: 0.96; Pearson's r: 0.94 (Castro-Rodrigues et al., 2018).

Hospital Anxiety and Depression Scale (HADS)

Zigmond and Snaith (1997) developed a 14-item self-report measure to assess the level of severity of anxiety and depression. The ratings for each item range from 0 to 3 (higher levels imply greater discomfort). Kumari et al. (2020) and Rishi et al. (2017) found internal consistency for anxiety ($\alpha = 0.80$) and depression ($\alpha = 0.76$).

WHO Quality of Life-BREF (WHOQOL-BREF)

A 26-item questionnaire evaluates four QOL domains: physical, psychological, social, and environmental (WHOQOL Group, 1997). Internal consistency (Cronbach's alpha): 0.62-0.86 (Raj, 2014; Saxena et al., 1998).

Procedure and Administration

Ethical clearance was obtained from the Institutional Ethics Committee of Ashoka Neuro Psychiatric Hospital and Lovely Professional University before data collection. Participants were screened using the Y-BOCS for OCD symptoms, followed by the Y-BOCS Symptom Checklist to assess the presence of sexual and religious obsessions. The HADS was administered to measure anxiety and depression, while the WHOQOL-BREF assessed quality of life. Structured interviews were conducted, ensuring confidentiality and voluntary participation.

Screening Process

The study followed a five-step screening process to ensure a comprehensive assessment:

1. Ethical Approval: Obtaining permission from the hospital's Institutional Ethics Committee.
2. OCD Diagnosis: Identifying symptoms using the Y-BOCS.
3. Obsessions Classification: Assessing sexual and religious obsessions via the Y-BOCS Symptom Checklist.
4. Clinical Correlates: Evaluating anxiety and depression using HADS.
5. Quality of Life Assessment: Measuring QOL using WHOQOL-BREF.

This structured methodology ensures a thorough examination of OCD symptoms, clinical correlates, and their impact on quality of life, contributing to a comprehensive understanding of the disorder's psychosocial implications.

Statistical analysis

This study employs various statistical methods to investigate sexual and religious obsessions in adults with OCD, their clinical correlates, and their impact on quality of life (QOL). Descriptive statistics using SPSS (version 26) analyse the prevalence of these obsessions, while Pearson's correlation assesses relationships with anxiety, depression, and QOL. Structural Equation Model (SEM) via AMOS (version 23) examines the mediating effects of clinical

correlates and the moderating role of QOL. Gender differences are evaluated through Crosstab Analysis and Chi-Square Tests, while ANOVA further analyses QOL differences. The findings aim to enhance understanding and inform therapeutic interventions for OCD patients experiencing sexual and religious obsessions.

5.1 Summary of Major Findings

- The study identified significant findings regarding the prevalence of sexual obsessions in adults with OCD. The study revealed that 31% of adults with OCD experienced sexual obsessions, with 13% reporting them alone and 18% alongside religious obsessions. While 69% did not report sexual obsessions, the significant prevalence highlights the need for clinical attention. Sexual obsessions can severely impact mental health and quality of life, often remaining unaddressed due to feelings of shame, guilt, and social withdrawal. This reluctance to seek help may stem from individuals misinterpreting their intrusive thoughts as moral failings rather than recognising them as OCD symptoms (Pozza et al., 2020; Gordon, 2002).
- The study examined the prevalence of religious obsessions in adults with OCD, revealing that 38% of participants experienced such obsessions. Among them, 20% reported religious obsessions alone, while 18% experienced them alongside sexual obsessions. In contrast, 62% did not report religious obsession. Religious obsessions often involve intrusive thoughts about blasphemy, morality, sin, or excessive rituals, contributing to significant distress and compulsive behaviours. These obsessions can severely impact mental well-being and quality of life, underscoring the need for targeted clinical interventions to address their psychological burden (Sharma et al., 2021).
- Anxiety and depression emerged as significant clinical correlates in OCD patients. Anxiety was positively correlated with depression ($r = .436$), while both were negatively associated with quality of life (QOL) ($r = -.500$ and $r = -.567$, respectively). Physical ($r = .740$) and psychological health ($r = .768$) positively influenced QOL and were inversely related to anxiety and depression. Additionally, social relationships ($r = .628$) and environmental factors ($r = .854$) showed strong positive associations with QOL. These findings emphasise the detrimental impact of anxiety and depression on overall well-being and the importance

of interventions that promote mental well-being to improve QOL (Beck & Greenberg, 1984).

- The study examined the mediating roles of anxiety and depression in the relationship between sexual and religious obsessions with OCD severity. OCD severity significantly predicted both anxiety and depression ($p < .001$). While religious obsessions predicted depression ($p = .023$) but not anxiety, sexual obsessions had no significant link to either. Depression partially mediated the relationship between religious obsessions and OCD severity, whereas anxiety showed no mediating effect. The absence of mediating effects for sexual obsessions may reflect their stronger link to shame and identity concerns rather than anxiety or depressive symptoms (Shafran et al., 1996; Rakesh et al., 2021; Abramowitz et al., 2025).
- The study found that quality of life (QOL) moderated the relationship between religious obsessions and OCD severity ($p = .008$), suggesting that improved QOL may reduce distress linked to religious obsessions. However, no such moderating effect was observed for sexual obsessions, which may persist despite better QOL due to their strong association with shame, guilt, and internal conflict. These findings highlight the protective role of enhancing QOL for individuals with religious obsessions while also emphasising the need for targeted interventions to address the shame and stigma associated with sexual obsessions (Gordon, 2002; Boger et al., 2020; Garg et al., 2023).
- The study examined gender differences in OCD patients with sexual and religious obsessions. Results showed no significant gender differences in the occurrence of sexual ($p = .083$) or religious obsessions ($p = .142$). This suggests that treatment approaches addressing these obsessions may not require gender-specific adjustments (Barman et al., 2023; Steinberg et al., 2016).
- The study found a significant difference in quality of life (QOL) among OCD subgroups with sexual and religious obsessions ($F = 4.102, p = 0.009$). Post hoc analysis (Tukey HSD) indicated that individuals with sexual obsessions had significantly poorer QOL than those without sexual and religious obsessions ($p = 0.008$). Other subgroup differences were not statistically significant. These findings suggest that sexual obsessions uniquely impair

QOL, emphasising the need for targeted interventions (Żerdziński et al., 2022). This result aligns with Remmerswaal et al. (2016), which highlighted the stronger negative impact of sexual obsessions on QOL compared to religious obsessions.

Table 5.1: <i>Summarises the findings of the hypotheses tested in this study.</i>		
S.no.	Hypothesis	Status
H1	There will be no sexual obsessions in adults with OCD.	Rejected
H2	There will be no religious obsession in adults with OCD.	Rejected
H3	There will be no clinical correlates (anxiety and depression) in adults with OCD.	Rejected
H4a	There will be no mediating effect of depression in the relationship between religious obsession with OCD.	Rejected
H4b	There will be no mediating effect of depression in the relationship between sexual obsession with OCD.	Fail to Reject
H4c	There will be no mediating effect of anxiety in the relationship between religious obsession with OCD.	Fail to Reject
H4d	There will be no mediating effect of anxiety in the relationship between sexual obsession with OCD.	Fail to Reject
	There will be no mediating effect of clinical correlates (anxiety and	

H4 (Overall)	depression) in the relationship between sexual and religious obsession with OCD.	Partially Supported
H5a	There will be no moderating effects on the Quality of Life (QOL) of people with religious obsessions in OCD.	Rejected
H5b	There will be no moderating effects on the Quality of Life (QOL) of people with sexual obsessions in OCD.	Fail to Reject
H5 (Overall)	There will be no moderating effects on the QOL of people with sexual and religious obsessions in OCD (Overall)	Partially Supported
H6	There will be no significant difference in adults having a sexual and religious obsession with OCD in relation to Gender.	Fail to Reject
H7	There will be no significant difference in the quality of life of people suffering from sexual and religious obsessions with OCD.	Rejected

5.2 Conclusion

This study emphasises the distressing aspect of sexual and religious obsessions, clinical correlates, and quality of life (QOL) in individuals with OCD. Sexual and religious obsessions are significant and distressing, each with distinct psychological implications. Religious obsessions are strongly linked to depressive symptoms, which mediate their influence on OCD severity. In contrast, sexual obsessions persist independently of QOL, suggesting a unique burden that may manifest through shame or identity distress, as noted by Kutty-Pachecka (2021) and Steinberg et al. (2016).

From a psychodynamic perspective, unresolved conflicts during psychosexual development may contribute to sexual obsessions (Choudhary et al., 2022), while cultural and religious beliefs may shape the manifestation of religious obsessions. This underscores the need for culturally aware therapies that address these obsessions (Taha Burak Toprak & Hanne Nur Özçelik, 2024).

The study emphasises that anxiety and depression significantly impair QOL among people with OCD, necessitating a holistic treatment approach. QOL was found to moderate the relationship between religious obsessions and OCD severity, with higher QOL linked to reduced OCD severity about religious obsessions. Conversely, QOL did not moderate the impact of sexual obsessions, highlighting the need for targeted interventions such as cognitive-behavioural therapy (CBT) and stigma-reducing strategies to address their persistent distress. Improving QOL may alleviate distress linked to religious obsessions, further reinforcing its role as a key treatment focus.

The co-occurrence of sexual and religious obsessions necessitates comprehensive assessment and ongoing monitoring to prevent symptom escalation. Tailored interventions, including cognitive therapy, exposure and response prevention, Acceptance and Commitment Therapy, and sexuality-focused therapies, are recommended to alleviate the psychological burden associated with these obsessions (Pozza et al., 2020; Siev et al., 2011; Dehaghi et al., 2024). The absence of significant gender differences indicates that treatment approaches addressing these obsessions may not require gender-specific adjustments. Future research should further explore cultural, religious, and psychological factors influencing obsessional themes (Steketee et al., 2011; Pallanti et al., 2011). These findings emphasise the importance of personalised, culturally informed interventions to improve QOL outcomes and enhance overall well-being in individuals with OCD.

5.3 Implications

Clinical Practice

- Highlights the importance of comprehensive assessment for OCD, particularly in cases involving sexual and religious obsessions, which are often underreported due to stigma (Rakesh et al., 2021; Shabnam & Mishra, 2020).

- Recommends evidence-based treatment approaches for managing sexual and religious obsessions in OCD, including CBT with Exposure and Response Prevention (ERP), Acceptance and Commitment Therapy (ACT), and Selective Serotonin Reuptake Inhibitors (SSRIs) (Dehaghi et al., 2024; Koolwal et al., 2022).
- Stresses the need for culturally sensitive interventions, recognising how cultural and sociodemographic factors influence symptom expression and treatment outcomes (Bilekli & Inozu, 2018; Sharma et al., 2021).
- Emphasises that, given no significant gender differences in obsession severity, treatment approaches should remain universal rather than gender-specific (Barman et al., 2023).

Public Health Perspective

- Calls for public health initiatives to reduce the stigma associated with sexual and religious obsessions in OCD and to promote early diagnosis and treatment-seeking behaviour (Rakesh et al., 2021; Shabnam & Mishra, 2020).
- Encourages future research to conduct longitudinal studies to understand causal relationships and explore neurobiological, genetic, environmental, and cultural influences on OCD symptoms (Pinto et al., 2006; Stein et al., 2019; Williams et al., 2011; Lima et al., 2023; Wu et al., 2018).
- Advocates for holistic care models to enhance Quality of Life (QOL) by addressing the negative effects of these obsessions on physical and social well-being (Pozza et al., 2020; Żerdziński et al., 2022).
- Suggests using theoretical frameworks such as the psychodynamic perspective, the Five-Factor Model of Personality, Maslow's Hierarchy of Needs, and the PERMA model to design comprehensive interventions (Bilekli & Inozu, 2018; Choudhary et al., 2022; Sirgy, 1986; Seligman, 2012).

Policy Implications

- Urges policy-level action to improve the training of mental health professionals in recognising and managing culturally sensitive OCD subtypes (Stein et al., 2019; Steinberg & Wetterneck, 2016).
- Emphasise the need to integrate evidence-based, culturally tailored care as a standard practice within mental health services.

5.4 Strengths and Limitations of the Study

Strengths

- The study explores sexual and religious obsessions in OCD, addressing an underexplored area and filling critical gaps in existing literature (Kuty-Pachecka, 2021; Steinberg et al., 2016).
- It examines the relationship between OCD symptoms, anxiety, and depression, emphasising the need for holistic treatment approaches based on Maslow's hierarchy of needs and the PERMA model (Surles, 2024).
- The study considers cultural perceptions of sexuality and religiosity, particularly in India, offering insights for culturally tailored interventions (Koolwal et al., 2022).
- It explores gender differences in sexual and religious obsessions, contributing to the development of more personalised treatment approaches.
- It incorporates psychodynamic, neurobiological, and cognitive-behavioural perspectives, providing a multifaceted understanding of OCD (Choudhary et al., 2022).
- The study uses standardised and psychometrically reliable instruments, including the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) ($\alpha = 0.96$, $r = 0.94$) (Goodman et al., 1989). Hospital Anxiety and Depression Scale (HADS) ($\alpha = 0.80$, 0.76) (Zigmond & Snaith, 1997). WHO Quality of Life-BREF (WHOQOL-BREF) ($\alpha = 0.62$ – 0.86) (WHOQOL Group, 1997).
- The findings contribute to clinical practice, theoretical advancements, and future research, enhancing the understanding of OCD subtypes.

Limitations

- A sample of 100 participants limits the generalisability of the findings. Future studies should incorporate larger and more diverse samples to improve external validity.
- The study's cross-sectional design prevents causal inferences between clinical correlates, obsessions, and quality of life (QOL). Longitudinal studies are needed to track symptom progression over time.
- The findings are context-specific to India and may not fully represent individuals from other cultural backgrounds. Cross-cultural comparisons are necessary for broader applicability.
- Reliance on self-reported measures introduces potential biases, as participants may underreport or overreport symptoms due to stigma or personal perceptions.

- While insightful, the study focuses solely on sexual and religious obsessions, excluding other OCD subtypes, which may limit the broader understanding of the disorder.
- The study emphasises tailored treatments but does not directly evaluate specific therapeutic approaches, such as CBT, ERP, ACT, or SSRIs, making it difficult to assess their comparative effectiveness.
- While the psychodynamic perspective provides valuable theoretical insights, its role in OCD symptomatology remains speculative and requires empirical validation.
- Conclusion: Despite these limitations, this study significantly contributes to the understanding of OCD, providing a foundation for future research.

5.5 Future Directions

Future research on sexual obsession, religiosity, clinical correlates, and quality of life (QOL) in OCD should focus on several key areas to enhance understanding and treatment outcomes:

- Longitudinal studies on sexual and religious obsessions, emotional correlates (e.g., anxiety, depression), and influence on QOL will provide deeper insights for targeted interventions (Steketee et al., 2011; Pallanti et al., 2011).
- The current study used quantitative methods. In the future, a mixed-method approach with both qualitative and quantitative design can be effective for gaining an in-depth knowledge of OCD with sexual and religious obsessions.
- To improve generalisability, research should involve diverse groups from different cultural, socioeconomic, and geographical backgrounds, particularly in sensitive areas such as sexuality and religion.
- Neurobiological and genetic research on sexual and religious obsessions can improve therapy personalisation (Mataix-Cols et al., 2022; Reimer et al., 2018).
- Understanding the impact of cultural norms and environmental factors on symptom manifestation and treatment response can lead to more effective therapies.
- Evaluating CBT (ERP), ACT, the 4T Model, and pharmaceutical therapies (SSRIs) across varied groups can reveal the most successful intervention techniques (Dehaghi et al., 2024; Larmar et al., 2014; Toprak, 2024; Williams et al., 2011).
- Integrating psychodynamic and integrative models may reveal underlying psychosexual problems in OCD, expanding therapy choices (Steinberg et al., 2016).

- Future research should focus on universal treatment methods for sexual and religious obsessions, as there are no substantial gender differences (Barman et al., 2023).
- Developing culturally appropriate and standardised assessment tools may reduce reliance on self-reported measures, enhancing diagnosis accuracy and treatment evaluation.

By addressing these areas, future research can contribute to reducing stigma, improving treatment outcomes, and enhancing QOL for individuals with OCD experiencing sexual and religious obsessions.

5.6 Challenges Faced by Researchers and Patients

Researchers frequently face significant obstacles when examining sensitive subjects such as sexual and religious obsessions in OCD. These include challenges in recruiting participants due to social desirability bias, stigma, and reluctance to disclose taboo or distressing thoughts. The research process becomes even more complex when ethical requirements, confidentiality, and participant discomfort are considered. To overcome these challenges, the researcher ensured strict confidentiality, fostered a non-judgmental environment, and employed validated, anonymous self-report tools to encourage honest disclosure and participation.

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DETAILS OF RESEARCH PUBLICATIONS/CONFERENCES/ WORKSHOPS

S.No.	Title of paper with author names	Name of journal / conference/workshop	Published date	Issn no/ vol no, issue no	Indexing in Scopus/ Web of Science/UGC-CARE list (please mention)
1.	<p>“Exploring Sexual Obsession In Obsessive- Compulsive Disorder: Prevalence, Demographic Correlates, And Clinical Implication For Anxiety And Depression”.</p> <p>Ankuna Sharma & Dr. Zahoor Ahmad Lone</p>	Journal of Neonatal Surgery	2025	Vol. 14, Issue: 4s	Scopus
2.	<p>“Scrupulosity in Obsessive-Compulsive Disorder Patients: A Systematic Literature Review and Bibliometric Analysis from 2000 to 2023”.</p>	Journal of Neonatal Surgery	2025	Vol. 14, Issue: 13s	Scopus

	Ankuna Sharma, Dr. Zahoor Ahmad Lone & Aarti Singh				
3.	Quality of Life and Psychosocial Impairment in Obsessive-Compulsive Disorder: The Differential Impact of Sexual and Religious Obsession. Ankuna Sharma & Dr. Zahoor Ahmad Lone	Journal of Carcinogenesis	2025	Vol. 24, Issue: 2s	Scopus
4.	Bibliometric Analysis on Sexual Obsession in OCD Patients from 2010 to 2023. Ankuna Sharma & Dr. Zahoor Ahmad Lone	International Conference on Mental Health at Crossroad (Department of Psychology) (University of Rajasthan, Jaipur).	23-24 Feb, 2024	-----	Conference
5.	Scrupulosity in Obsessive-Compulsive Disorder Patients: A Systematic Literature Review and Bibliometric Analysis from 2000 to 2023. Ankuna Sharma & Dr. Zahoor Ahmad Lone	International Conference On Positive Psychology by NPPA.	19-20 April, 2024	-----	Conference
6.	Sexual Disorders and Dysfunctions.	Course on Sexual Disorders and dysfunctions. by Tejal Kothari	27 sept, 2023 to 9 Oct, 2023	-----	Workshop

7.	Anxiety Disorder	Workshop on Understanding Anxiety Disorder with Case Studies by Dr. Pankhuri, Consultant Psychiatrist.	6 Aug, 2024	-----	Workshop
8.	Research Methodology and Data Analytics	Workshop on Research Methodology and Data Analytics. Organized by Digvijai Nath Post Graduate Collage, Gorakhpur, Lucknow, UP.	21-27 Oct, 2024	-----	Workshop
9.	Case History Taking & MSE.	Workshop on Case History Taking & MSE. by Tejal Kothari	22 Sept, 2023	-----	Workshop
10.	Scale construction and standardization	Course on scale construction and standardization workshop by Lovely Professional University	20-25 Feb, 2023	-----	Workshop
11.	Major Depression Disorder	Workshop On Major Depression Disorder by Tejal Kothari	26 Nov, 2023	-----	Workshop

12.	Statistical Data Analysis & Interpretation Using MS Excel	International Workshop On Statistical Data Analysis & Interpretation Using MS Excel. organized by Dept. of Research & Publications	27-28-29 Dec, 2023	-----	Workshop
13.	Ethics in Biomedical Research, Systematic Review and Meta Analysis	Workshop Cum Hands-on Training: Ethics in Biomedical Research, Systematic Review and Meta Analysis organized by Lovely Professional University	27-28 Aug, 2024	-----	Workshop
14.	Data Analysis with SPSS.	Workshop on Data Analysis with SPSS. Organized by Commacad	13-14 April, 2024	-----	Workshop



Ref: LPU/IEC-LPU/2024/3/10
Date: 12.09.24

Dear Ankuna Sharma

The Institutional Ethics Committee, Lovely Professional University (IEC-LPU) reviewed and discussed your application to conduct the study entitled **“Sexual obsession, religiosity, clinical correlates and quality of life among people with obsessive-compulsive disorder (OCD)”**.

The following documents were reviewed:

- (a) Application form
- (b) Research Protocol
- (c) Patient information sheet and informed consent form in English or vernacular language.
- (d) Principal investigator’s current Curriculum Vitae.

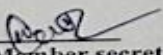
The following members of the ethics committee were present at the meeting held on 23.08.24.

Sr. No.	Name	Designation as per IEC
1	Dr. Shivani Tandon	Chairperson
2	Dr. Navneet Khurana	Member Secretary
3	Dr. Kanav Khera	Alternate Member Secretary
4	Dr. Varun Gupta	Basic Medical Scientist
5	Dr. Anil Malhotra	Clinician-I
6	Dr. Naresh Kundra	Clinician-II
7	Dr. Meenu Chopra	Legal expert
8	Mr. Sumesh Mathew	Social Scientist/Philosopher/Ethicist/Theologian
9	Dr. Rajan Kumar Sharma	Layperson

The Ethics committee approved the study to be conducted in its presented form subject to the condition of

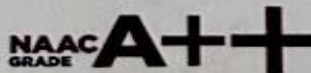
- The principal investigator and all members of the project shall ensure compliance with current regulatory provisions (as per New Drug Clinical Trial Rules 2019 and ICH-GCP), Ethical Guidelines for Biomedical Research on Human Participants by ICMR, and the standard operating procedure of IEC including timely submission of Interim Annual Report and Final Closure Report.
- Participant Information Sheet and a copy of signed Informed Consent shall be given to every research participant.
- Inform IEC in case of any proposed amendments (change in protocol/procedure, site/investigator, etc).
- Inform IEC immediately in case of any Adverse Events and Serious Adverse Events.
- Members of the IEC have the right to monitor any project with prior intimation.

Yours sincerely,


Chairperson/Member secretary/Alternate member secretary, IEC-LPU

Member Secretary
Institutional Ethics Committee
Lovely Professional University
Phagwara-Punjab-144411

12.09.24
dd/mm/yyyy



Appendices 1

CONSENT- FORM

I, Ankuna Sharma, a Research Scholar at the Department of Psychology, Lovely Professional University, Punjab, invite you to participate in my Ph.D. research study. The purpose of this study is to examine the prevalence of sexual and religious obsessions in individuals diagnosed with Obsessive-Compulsive Disorder (OCD), along with associated clinical correlates such as anxiety and depression.

Understanding these factors is essential for improving the mental health care and quality of life of those affected.

Your participation in this research is completely voluntary. You may choose not to take part or to withdraw at any point without facing any negative outcomes. The survey is expected to take around 60 minutes. All the information you provide will remain confidential and will be used solely for educational and research purposes.

If you have any questions or need further clarification about the study, please feel free to ask.

Participant Declaration

I have read and understood the information presented above. I willingly agree to participate in this research study.
I confirm that I am 18 years of age or older.

Name of the patient :

Signature with date:

सहमति पत्र

मैं, अंकुना शर्मा, जो कि लवली प्रोफेशनल यूनिवर्सिटी, पंजाब के मनोविज्ञान विभाग में एक शोधार्थी हूँ, आपको मेरे पीएच.डी. शोध अध्ययन में भाग लेने के लिए आमंत्रित करती हूँ। इस अध्ययन का उद्देश्य ऑब्सेसिव-कम्पल्सिव डिसऑर्डर (OCD) से पीड़ित व्यक्तियों में यौन और धार्मिक जुनून की व्यापकता और उनसे संबंधित नैदानिक कारकों जैसे कि चिंता और अवसाद का मूल्यांकन करना है। इन पहलुओं को समझना मानसिक स्वास्थ्य देखभाल और प्रभावित व्यक्तियों के जीवन की गुणवत्ता में सुधार लाने के लिए अत्यंत आवश्यक है। इस अध्ययन में आपकी भागीदारी पूरी तरह से स्वैच्छिक है, और आप किसी भी समय बिना किसी दंड या नकारात्मक प्रभाव के इससे हट सकते हैं। इस सर्वेक्षण को पूरा करने में लगभग 60 मिनट का समय लगेगा। आपकी दी गई सभी जानकारी को गोपनीय रखा जाएगा और केवल शैक्षणिक और शोध उद्देश्यों के लिए उपयोग किया जाएगा। यदि आपके कोई प्रश्न हैं या इस अध्ययन के बारे में और स्पष्टीकरण की आवश्यकता है, तो कृपया निःसंकोच पूछें।

प्रतिभागी की घोषणा

मैंने ऊपर दी गई जानकारी को पढ़ लिया है और समझ लिया है। मैं स्वेच्छा से इस शोध अध्ययन में भाग लेने के लिए

सहमत हूँ। मैं पुष्टि करता/करती हूँ कि मेरी आयु 18 वर्ष या उससे अधिक है।

रोगी का नाम:

हस्ताक्षर एवं दिनांक:

List of Appendices

Appendices 2 The Yale-Brown Obsession-Compulsive Disorder Scale <https://pandasnetwork.org/wp-content/uploads/2018/11/y-bocs-w-checklist.pdf>

Appendices 3 Hospital Anxiety and Depression Scale <https://www.svri.org/sites/default/files/attachments/2016-01-13/HADS.pdf>

Appendices 4 WHO Quality of Life-BREF <https://apps.who.int/iris/bitstream/handle/10665/63529/WHOQOL-BREF.pdf?sequence=1>

PATIENT

22.

NAME

DATE

YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)*

Questions 1 to 5 are about your obsessive thoughts

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by circling the appropriate number.

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS SCORE _____

How much of your time is occupied by obsessive thoughts?

- 0 = None
- 1 = Less than 1 hr/day or occasional occurrence
- 2 = 1 to 3 hrs/day or frequent
- 3 = Greater than 3 and up to 8 hrs/day or very frequent occurrence
- 4 = Greater than 8 hrs/day or nearly constant occurrence

2. INTERFERENCE DUE TO OBSESSIVE THOUGHTS SCORE _____

How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

- 0 = None
- 1 = Slight interference with social or other activities, but overall performance not impaired
- 2 = Definite interference with social or occupational performance, but still manageable
- 3 = Causes substantial impairment in social or occupational performance
- 4 = Incapacitating

3. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS SCORE _____

How much distress do your obsessive thoughts cause you?

- 0 = None
- 1 = Not too disturbing
- 2 = Disturbing, but still manageable
- 3 = Very disturbing
- 4 = Near constant and disabling distress

4. RESISTANCE AGAINST OBSESSIONS SCORE _____

How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

- 0 = Try to resist all the time
- 1 = Try to resist most of the time
- 2 = Make some effort to resist
- 3 = Yield to all obsessions without attempting to control them, but with some reluctance
- 4 = Completely and willingly yield to all obsessions

5. DEGREE OF CONTROL OVER OBSESSIVE THOUGHTS SCORE _____
- How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?
- | | | |
|---|---|---|
| 0 | = | Complete control |
| 1 | = | Usually able to stop or divert obsessions with some effort and concentration |
| 2 | = | Sometimes able to stop or divert obsessions |
| 3 | = | Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty |
| 4 | = | Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking. |

The next several questions are about your compulsive behaviors.

Compulsions are urges that people have to do something to lessen feelings of anxiety or other discomfort. Often they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental. For example, thinking or saying things over and over under your breath.

6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS SCORE _____
- How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals?
- | | | |
|---|---|---|
| 0 | = | None |
| 1 | = | Less than 1 hr/day or occasional performance of compulsive behaviors |
| 2 | = | From 1 to 3 hrs/day, or frequent performance of compulsive behaviors |
| 3 | = | More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors |
| 4 | = | More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count) |

7. INTERFERENCE DUE TO COMPULSIVE BEHAVIORS SCORE _____
- How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions?
- | | | |
|---|---|---|
| 0 | = | None |
| 1 | = | Slight interference with social or other activities, but overall performance not impaired |
| 2 | = | Definite interference with social or occupational performance, but still manageable |
| 3 | = | Causes substantial impairment in social or occupational performance |
| 4 | = | Incapacitating |

8. DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIOR SCORE _____

How would you feel if prevented from performing your compulsion(s)? How anxious would you become?

- | | | |
|---|---|--|
| 0 | = | None |
| 1 | = | Only slightly anxious if compulsions prevented |
| 2 | = | Anxiety would mount but remain manageable if compulsions prevented |
| 3 | = | Prominent and very disturbing increase in anxiety if compulsions interrupted |
| 4 | = | Incapacitating anxiety from any intervention aimed at modifying activity |

9. RESISTANCE AGAINST COMPULSIONS SCORE _____

How much of an effort do you make to resist the compulsions?

- | | | |
|---|---|--|
| 0 | = | Always try to resist |
| 1 | = | Try to resist most of the time |
| 2 | = | Make some effort to resist |
| 3 | = | Yield to almost all compulsions without attempting to control them, but with some reluctance |
| 4 | = | Completely and willingly yield to all compulsions |

10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR SCORE _____

How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

- | | | |
|---|---|---|
| 0 | = | Complete control |
| 1 | = | Pressure to perform the behavior but usually able to exercise voluntary control over it |
| 2 | = | Strong pressure to perform behavior, can control it only with difficulty |
| 3 | = | Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty |
| 4 | = | Drive to perform behavior experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity. |

 TOTAL SCORE _____

Y-BOCS Symptom Checklist

Instructions: Generate a *Target Symptoms List* from the attached Y-BOCS Symptom Checklist by asking the patient about specific obsessions and compulsions. Check all that apply. Distinguish between current and past symptoms. Mark principal symptoms with a "p". These will form the basis of the *Target Symptoms List*. Items marked may "*" or may not be an OCD phenomena.

Current Past

AGGRESSIVE OBSESSIONS

- Fear might harm self
- Fear might harm others
- Violent or horrific images
- Fear of blurting out obscenities or insults
- Fear of doing something else embarrassing*
- Fear will act on unwanted impulses (e.g., to stab friend)
- Fear will steal things
- Fear will harm others because not careful enough (e.g. hit/run motor vehicle accident)
- Fear will be responsible for something else terrible happening (e.g., fire, burglary)

Other: _____

CONTAMINATION OBSESSIONS

- Concerns or disgust w/ with bodily waste or secretions (e.g., urine, feces, saliva) Concern with dirt or germs
- Excessive concern with environmental contaminants (e.g. asbestos, radiation toxic waste)
- Excessive concern with household items (e.g., cleansers solvents)
- Excessive concern with animals (e.g., insects)
- Bothered by sticky substances or residues
- Concerned will get ill because of contaminant
- Concerned will get others ill by spreading contaminant (Aggressive)
- No concern with consequences of contamination other than how it might feel

SEXUAL OBSESSIONS

- Forbidden or perverse sexual thoughts. images. or impulses
- Content involves children or incest
- Content involves homosexuality*
- Sexual behavior towards others (Aggressive)*
- Other: _____

HOARDING/SAVING OBSESSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value)

RELIGIOUS OBSESSIONS (Scrupulosity)

- Concerned with sacrilege and blasphemy
- Excess concern with right/wrong, morality
- Other: _____

OBSESSION WITH NEED FOR SYMMETRY OR EXACTNESS

- Accompanied by magical thinking (e.g., concerned that another will have accident dent unless less things are in the right place)
- Not accompanied by magical thinking

MISCELLANEOUS OBSESSIONS

- Need to know or remember
- Fear of saying certain things
- Fear of not saying just the right thing
- Fear of losing things
- Intrusive (nonviolent) images
- Intrusive nonsense sounds, words, or music
- Bothered by certain sounds/noises*
- Lucky/unlucky numbers
- Colors with special significance
- 3 superstitious fears
- Other: _____

Current Past

SOMATIC OBSESSIONS

- Concern with illness or disease*
- Excessive concern with body part or aspect of Appearance (eg., dysmorphophobia)*
- Other _____

CLEANING/WASHING COMPULSIONS

- Excessive or ritualized handwashing
- Excessive or ritualized showering, bathing, toothbrushing grooming, or toilet routine Involves cleaning of household items or other inanimate objects
- Other measures to prevent or remove contact with contaminants
- Other _____

CHECKING COMPULSIONS

- Checking locks, stove, appliances etc.
- Checking that did rot/will not harm others
- Checking that did not/will not harm self
- Checking that nothing terrible did/will happen
- Checking that did not make mistake
- Checking tied to somatic obsessions
- Other: _____

REPEATING RITUALS

- Rereading or rewriting
- Need to repeat routine activities jog, in/out door, up/down from chair)
- Other _____

COUNTING COMPULSIONS

ORDERING/ARRANGING COMPULSIONS

HOARDING/COLLECTING COMPULSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value (e.g., carefully reads junk mail, piles up old newspapers, sorts through garbage, collects useless objects.)

MISCELLANEOUS COMPULSIONS

- Mental rituals (other than checking/counting)
- Excessive listmaking
- Need to tell, ask, or confess
- Need to touch, tap, or rub*
- Rituals involving blinking or staring*
- Measures (not checking) to prevent: harm to self - harm to others terrible consequences
- Ritualized eating behaviors*
- Superstitious behaviors
- Trichotillomania *
- Other self-damaging or self-mutilating behaviors*
- Other _____

Adapted from Goodman, W.K., Price, L.H., Rasmussen, S.A. et al.:
"The Yale-Brown Obsessive Compulsive Scale."
Arch Gen Psychiatry 46:1006-1011,1989

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			I feel as if I am slowed down:
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			I get a sort of frightened feeling like 'butterflies' in the stomach:
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			I have lost interest in my appearance:
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			I feel restless as I have to be on the move:
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			I look forward with enjoyment to things:
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			I get sudden feelings of panic:
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			I can enjoy a good book or radio or TV program:
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

ABOUT YOU

I.D. number

--	--	--	--

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your **gender**? **Male** **Female**
 What is your **date of birth**? _____ / _____ / _____
 Day / **Month** / **Year**

What is the highest education you received? **None at all**
 Primary school
 Secondary school
 Tertiary

What is your **marital status**? **Single** **Separated**
 Married **Divorced**
 Living as married **Widowed**

Are you currently ill? **Yes** **No**

If something is wrong with your health what do you think it is? _____ illness/ problem

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks. For example, thinking about the last two weeks, a question might ask:

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about how much you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

Do you have any comments about the assessment?

.....
.....

THANK YOU FOR YOUR HELP