The Review of Contemporary Scientific and Academic Studies
An International Multidisciplinary Online Journal
www.thercsas.com
ISSN: 2583-1380 Vol. 5 | Issue No. 03 | March 2025 Impact Factor: 6.53

The Role of Gender and Culture in Shaping the Experience of Sexual Obsessions in Women with Obsessive Compulsive Disorder: A Case Series

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 Crossref/DOI: https://doi.org/10.55454/rcsas.5.03.2025.004

Abstract: *The experiences associated with having sexual obsessions in Obsessive-compulsive disorder (OCD) is particularly under-reported and consequently under-researched especially in women hailing from conservative, rural backgrounds. This paper presents a unique case series of three women diagnosed with Obsessive Compulsive Disorder (OCD) according to the ICD-11 DCR with predominance of sexual obsessions from rural origin of Odisha, India. The symptomatology and experiences are shaped by their age, gender, cultural norms and other socio-demographic variables. Religious rituals and avoidance behaviours which are used to alleviate distress, further perpetuates the obsessive-compulsive cycle. The underlying feelings of shame and guilt prevents seeking of professional help and support. The findings highlight the necessity of creating interventions that are culturally relevant and merge different evidence-based treatments with comprehension of local dynamics. Enhancing mental health literacy and reduction of stigma is imperative to improve care and treatment outcomes in women with sexual obsessions.*

Keywords: Gender, Mental Health, OCD, Women with Sexual Obsessions

Article History: **Received: 06 March- 2025;** **Accepted: 15 March- 2025;** **Published/Available Online: 30 March- 2025**

Introduction

Obsessive-compulsive disorder (OCD) is the fourth leading debilitating mental health condition, with a lifetime prevalence of 1.1% to 1.8% within the general population. Even though both the genders are susceptible, females are 1.6 times more likely to be diagnosed. The lifetime prevalence rate compared to 1% for males, is 1.5% in females (Fawcett et al., 2020; Kiejna et al., 2002). Males generally experience the onset of OCD earlier in their lives, often in childhood, while for females, it more commonly arises in adolescence or early adulthood and, usually around puberty, pregnancy, or postpartum periods (Mathes et al., 2019; Noshirvani et al., 1991; Liu, 2023). Additionally, women are more inclined to conceptualize their experiences with OCD as a journey, whereas men frequently characterize them as a battle, thereby reflecting divergent coping strategies and social recovery trajectories (Campbell & Longhurst, 2013). The manifestations of the symptoms of OCD also exhibit gender differences. For instance, females are more likely to experience and seek help for obsessions and compulsions related to contamination, while males are more likely to report blasphemous thoughts and obsessions concerning symmetry with limited reporting of sexual obsessions especially by females (Mathes et al., 2019).

The rate of prevalence of sexual obsessions in individuals with OCD is estimated to be 16.8% (Kuty-Pachecka, 2021). Sexual obsessions in OCD is fundamentally distinct from the normative sexual behavior with respect to the nature of the obsessions and compulsions constitutive of the disorder. Sexual OCD, in contrast to normative sexual behavior, consists of intrusive, unwanted thoughts and compulsive actions that cause substantial distress and impair functioning across personal, social, and occupational domains. Many of the obsessive-compulsive characteristics of the disorder lead individuals to avoid any sexual situation, and this avoidance can harm relationships and sexual health (Marchetti, 2023; Boulton, 2020). The compulsions of sexual OCD are viewed as a distress-relieving action carried out of necessity rather than for pleasure, in contrast to conventional sexual behavior, which is usually pleasant and consensual (Abramowitz, 2007). Individuals suffering from sexual OCD may grapple with obsessions pertaining to sexual acts involving family members, animals, or religious figures, which can precipitate considerable feelings of shame and anxiety (Chaudhary et al., 2022; Shabnam & Mishra, 2020).

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ISSN: 2583-1380 Vol. 5 | Issue No. 03 | March 2025 Impact Factor: 6.53

One of the factors deciding treatment outcomes is stigma associated with the disorder. Stereotypes determine how the symptoms of the disorder are perceived culturally and becomes important especially when the OCD centres around sexual, harm or aggressive obsessions. The stigma surrounding this not only leads to exacerbation in distress but also deters the process of further treatment (Ponzini et al., 2023). Such obsessions may be considered as culturally unacceptable or taboo and individuals may avoid seeking psychological help due to intense shame and stigma associated with the same (Glazier et al., 2015). Not only does cultural factors play a crucial role in determining access to treatment and its outcomes but also shape the cognitive processes and symptom presentation in OCD. To take an example, the intensity of thought-action fusion which refers to the belief that merely thinking something adverse is same as performing it was found higher in Turkish culture, due to deeply ingrained moral and religious values. This fusion may make intrusive thoughts even more distressing and may also intensify the symptoms of OCD. Furthermore, cultural beliefs may also bear an influence on the strategies which the individuals may use to cope with their distressing thoughts. For example, in the study, worry was commonly used as coping mechanism by all Turkish groups, regardless of whether they lived in Turkey or Bulgaria, highlighting that cultural underpinnings affect the management of anxiety and obsessive thoughts (Yorulmaz & Işık, 2011). Therefore, sexual obsessions can be culturally bound, with differences in presentation across ethnicities and cultures. (Williams & Wetterneck, 2019).

Additionally, studies indicate that the content and intensity of obsessions may also be influenced by religion and religiosity. Obsessions with blasphemous themes can occur in extremely religious communities. Severe symptoms, such as excessive prayer and ritualistic actions, may result from the increased distress caused by such obsessions. The acts that are deemed more acceptable may also be determined by culture and religion. This affects the characteristics of obsessions as well as the behaviours used to deal with them. A need to develop interventions in therapy which are culturally sensitive is significant (Nicolini et al., 2018).

Building upon this understanding, we can understand that individuals with OCD may face unique challenges shaped by their cultural and religious belonging. These challenges may be more pronounced in OCD with sexual themes in conservative rural backgrounds, especially in case of women where even building conversations around sexuality may be considered a taboo topic. The societal stigma and shame associated with these obsessions can result in misdiagnosis and inadequate management, as many women may not openly discuss about these intrusive thoughts with the healthcare providers (Wetterneck & Williams, 2019). Thereby, sexual obsessions may be under-reported due to underlying shame and guilt and consequently understudied. To understand these dynamics within the rural socio-cultural context of India, this case series presents unique and diverse symptom presentations and experiences of OCD centered around sexual themes diagnosed as per ICD-11 DCR, among three women hailing from rural background from Odisha, India. Through presenting these cases, this series sheds light on culturally sensitive understanding necessary for therapeutic work with sexual obsessions, with a focus especially on women with similar socio-cultural backgrounds, building a more empathetic understanding of sexual OCD among underserved communities.

Case Reports

Case 1: A 64-year-old, married, Hindu female, studied up to standard 4th, homemaker, hailing from rural Odisha, India, presented to a mental health establishment with the chief complains of repeated thoughts of having intimate relationship with multiple men and animals, chanting the holy names of gods to get rid of those thoughts, excessive guilt and decrease interaction with everyone, decreased sleep and appetite, five suicide attempts in 15 days. The patient was apparently alright until five years ago when she first began experiencing intrusive thoughts specifically involving her son, son-in-law, and brother-in-law. Initially lasting four to six hours, these thoughts caused her severe distress, leading her to isolate herself and cry frequently. Over time, the intrusive thoughts extended to include other men visiting her home, and in the past month, even unknown men and animals like bullocks, dogs which are roaming around the streets. The duration of these thoughts gradually increased from 4 to 6 hours to 14 to 16 hours per day. In an effort to suppress them, she chanted holy names, which proved ineffective in providing her relief. She also attempted to confine herself to a closed room to avoid interactions due to feelings of excessive shame and guilt and often questioning why she is getting such thoughts at this age. Since, four years, she began avoiding social gatherings and family functions, becoming seclusive and significantly reducing her participation in household chores. She frequently experienced fatigue and spontaneous crying episodes. Her sleep progressively worsened, reducing to approximately four hours per night, and she significantly decreased her

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ISSN: 2583-1380 Vol. 5 | Issue No. 03 | March 2025 Impact Factor: 6.53

food intake. In the past 15 days, she attempted suicide five times. She had fairly adjusted premorbid personality.

Mental status examination revealed she being kempt, cooperative, in touch with reality, with decreased psychomotor activity. Her mood was depressed, and her affect was restricted and shallow, congruent with her mood. She reported feelings of worthlessness and hopelessness. Thought content revealed intrusive, vivid, ego-dystonic sexual obsessions, compulsions to chant holy names, excessive worry, and death wishes. No abnormality in perception was reported. She was oriented to time, place, and person, with impaired attention and concentration, immediate memory and intact recent and remote memory. Her thinking was semi-abstract, and insight was Grade V, as she recognized the irrational nature of her thoughts and sought help. A Y-BOCS score of 26 indicated severe OCD symptoms. Non-pharmacological interventions, such as psychoeducation and caregiver counselling were carried out and further sessions, were planned to address the compulsive rituals and intrusive thoughts.

Case 2: A 43-year-old, Hindu, widow from rural India, studied up to standard 9th, hailing from rural Odisha, presented with chief complains of repetitive, undesirable thoughts of engaging in sexual relationships with unknown men, sexual thoughts triggered by seeing fruits like bananas, repeated chanting of God's name whenever she experiences such thoughts, and persistent feelings of guilt and shame with onset of her symptoms being insidious, duration being 3 months and exacerbation since past one month. The patient was apparently alright three months back when she began experiencing intrusive and distressing sexual thoughts involving unknown men. Gradually, the content of her obsessions expanded, with everyday objects, such as bananas, triggering intrusive associations with male genitalia. These associations heightened her distress and led her to fear that her thoughts were reflective of her moral character as she believed it is completely unacceptable because of her status as a widow She frequently felt that death alongside her husband would have been preferable to enduring this pain and suffering. Her intrusive thoughts also began to involve sexual cuss words and slang terms, which she perceived to be embedded in normal, innocuous conversations. She became increasingly convinced that even thinking about these words was impure, leading her to engage in chanting "Rama Rama" as a way to get rid of the perceived sin. Chanting, however, provided her no much respite and she was unable to lessen the severity of the intrusive thoughts which started to interfere with her day-to-day activities. She started to distance herself from social and professional interactions, which made her feelings of guilt and loneliness worse. As her symptoms worsened over time, she began to feel depressed, despondent, and contemplated suicide. She was also unable to adequately care for her children because she struggled with simple domestic duties. She was only able to get four hours of sleep every night, and her appetite had drastically declined.

On mental status examination, she was fairly groomed and cooperative, her affect was depressed, and range was restricted. Thought content was preoccupied with intrusive sexual obsessions, guilt, and death wishes. Her insight into the irrational nature of her thoughts was Grade V, and a Y-BOCS score of 24 indicated severe OCD symptoms. With initial psychoeducation and thought normalization, further evaluation was planned, to address her obsessive thoughts and associated depressive symptoms.

Case 3: A 28-year-old, married, Hindu female, homemaker, hailing from rural lower socioeconomic background, presented with the chief complains of distressing, intrusive sexual thoughts about hugging and getting physically intimate with various men, including her father-in-law, authority figures and young children, excessively chanting mantras to alleviate intrusive thoughts, avoiding eye contact, interactions with men, somatic complains such as headaches, dizziness, and sleep disturbances since the past eight months. The patient was apparently alright eight months back, when she began experiencing recurrent intrusive sexual thoughts, particularly when seeing her father-in-law, elderly figures, and children. The thoughts provided considerable distress and feelings of guilt, disgust, and fear in her. The frequency of her intrusive thoughts increased to about 3-4 hours a day, and she chanted mantras of Lord Shiva whenever she gets such thoughts. In unbearable conditions, she would rush to the Lord Shiva temple and touch the idol of Lord Shiva, hugging it, hoping to cleanse her mind. She also made a mansik (religious vow) at the temple, requesting the end of her intrusive thoughts. Gradually, she became very avoidant, particularly with the male gender. Her gaze would drop, with no eye contact. She took extreme preventive measures to avoid situations where she risked encountering male figures. She became very avoidant socially and would not leave the house without her husband, even covering her face with her saree's veil so that she would not have to look at men. The constant distress from her intrusive thoughts and compulsions took a toll on her physical health,

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with symptoms such as headaches, dizziness, and sleep disturbances. She also struggled to maintain her household responsibilities, which contributed to her deepening sense of helplessness.

On mental status examination, she appeared kempt and tidy, her affect was anxious and her thought content preoccupied with obsessive sexual thoughts and compulsions. Her cognitive functions, including attention, memory, and judgment, were intact with insight of Grade V. She acknowledged the irrationality of her thoughts but felt powerless to control them. A Y-BOCS score of 22 indicates moderate OCD symptoms and non-pharmacological interventions, including CBT, were planned to address her compulsions and improve her ability to function in daily life.

Discussion

Socio-Demographic Analysis

All the three patients were women from rural background, from diverse age ranges, belonging to lower socio-economic strata of Hindu religion. They had varied marital statuses with two of them being married and one being a widow and levels of education. These factors determined their access to mental health care services, adoption of various coping strategies to avoid distress and this help us understand the societal lens through which their symptoms are interpreted. Belonging from rural background and elementary level of education, amplified the stigma associated with mental disorders especially when involving taboo topics such as sexual obsessions. The cultural milieu surrounding the women influence not only their understanding of the disorder but also the form of their compulsions in form of religious rituals which are culturally more accepted.

Cultural and Religious Underpinnings

Across the three cases, a major commonality is the use of religious mental rituals as a coping strategy by all the three women for managing the distress associated with the intrusive sexual thoughts. In these cases, culturally sanctioned practices—such as chanting holy names of Hindu deities, making religious vow at temple of Lord Shiva and repeatedly visiting his temple to avoid these thoughts (as seen in Case 3), and other ritualistic behaviors is present. Such practices serve as structured mechanisms of coping providing a temporary sense of relief from the distress. They also provide a predictable and repetitive framework that helps patients feel a sense of control over their intrusive thoughts. At the same time, religion also functions as a meaning-making system which helps individuals to find purpose and order in their experiences which is especially beneficial when they are trying to cope with the guilt and shame stemming from perceived 'sins' (Uden & Zondag, 2016). On the flip side, though these mental rituals may be culturally accepted and along the lines of religious norms, they reinforce the obsession-compulsion cycle. The sense of relief provided by these rituals is often short lived and perpetuates emotional dysregulation particularly when the severity of OCD increases. An important understanding here is that normative religious practices is often intertwined with the symptoms of the disorder. This, further, complicates the process of differentiation between pathological rituals and the acceptable religious practices and presents a diagnostic challenge. Also, presence of religious obsessions and compulsions is linked to poorer treatment outcomes due to the limited expertise of clinicians regarding culturally nuanced presentation of symptoms, as per previous studies (Abramowitz & Buchholz, 2020). Therefore, the clinicians must tread delicately and strike a balance between respect for cultural identity and beliefs and instilling effective coping skills. Therapeutic interventions may be challenging as the rituals are culturally and socially acceptable and because they are in nature intangible, thus demanding sensitive and subtle techniques.

Gender's Contribution to Distress

The distress that comes with sexual obsessions is much increased for women. For instance, in Case 2 the thoughts were seen as a personal flaw and as a sign of moral corruption due to excessive unexpressed internalized stigma associated with widowhood. Similarly, in Case 1, the thoughts according her at that age of 64 years was unacceptable to her and caused withdrawal and social isolation. In cultures where acceptance of one's sexuality as a female is highly regulated, such thoughts may challenge the internalized norms of purity and chastity. Other research indicates that internal stigma among people with OCD is associated with low quality of life and greater severity of symptoms (Ansari et al., 2020; Kiliç et al., 2022). In particular, in conservative societies, women internalize societal judgments that lead to an increase in self-blame. Women are expected to conform to moral integrity; any actual or perceived deviation from cultural or moral norms is

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thus subject to intense scrutiny. Studies by Bhuptani & Messman-Moore (2019) and Georgescu (2023) explain that this scrutiny makes women feel more guilt and shame which could result in more emotional suffering.

Avoidance Behaviours

A key strategy which is used by the women to manage the anxiety triggered by intrusive sexual thoughts is avoidance. Research has also shown that avoidance behaviours are reinforced negatively, thereby, providing a temporary sense of relief to the individuals by reducing their exposure to the stimuli which is causing them distress (Crummy et al., 2024). To take an instance, in Case 3, she refused to leave the house without her husband and actively avoided eye contact with men to prevent intrusive thoughts and in Case 1, the patient confined herself inside her room which leads to feelings of loneliness and depression. Avoidance impairs the social and occupational functioning and also reinforces the obsessive-compulsive cycle. It also causes functional impairment and decreases the quality of life (Kuty-Pachecka, 2021; Williams & Wetterneck, 2019). Research puts forward specific neural circuits such as circuits between dorsal anterior cingulate cortex and basolateral amygdala mediates traits of harm avoidance (Ghane et al., 2024). The psychological models indicate that avoidance behaviours in OCD may be driven by implicit motivational factors, occurring automatically rather than as a conscious decision (Marzuki et al., 2024). In exposure and response prevention therapy (ERP), in particular, this automaticity may provide difficulties since persistent avoidance might impede the cessation of compulsive behaviors. Patients who incorporate excessive avoidance patterns therefore demonstrate worse treatment outcomes with elevated chances of relapse (Wheaton et al., 2018; Wheaton et al., 2024; Martínez-Rivera et al., 2020).

Psychological Impact of Shame and Guilt

Shame, with its usual root in negative self-perception and violation of personal values, stands out especially in some individuals with OCD, particularly in intrusive sexual thoughts (Mavrogiorgou et al., 2024; Visvalingam et al., 2022). For example, in Case 1, the suicide attempts are attributed to the explosive feelings of shame and guilt that characterize that patient. These types of feelings can impede therapy by increasing avoidance and resistance to the treatment (Badour et al., 2020; McCann et al., 2023). Feelings of guilt in OCD is more related to the judgments individuals make over their own actions. It is based on fear of punishment and results in performance of compulsions to neutralize the aversive feelings (Kenny et al., 2022). Both shame and guilt contribute to both the maintenance and worsening of symptoms (Laving et al., 2022). Different emotional regulation strategies have been promising in the reduction of OCD symptoms and enhancing the efficacy of treatment.

Culturally Sensitive Intervention Strategies

In order to effectively manage obsessions especially with sexual themes, the interventions must be customized to the particular cultural, social, and economic context (Arip et al., 2018). This involves integrating cultural elements within the therapy, such as reframing religious rituals within evidence-based therapies like CBT and ERP, and building upon the existing community values (Gibbons et al., 2019). To reach rural people, a variety of context-relevant educational resources can be used (Hallum-Montes et al., 2016). It is extremely important to first engage in community stakeholders (Dass-Brailsford, 2012) to address internal stigma which is associated with loneliness and decreased quality of life. Internalized stigma may even delay psychiatric care by up to two years (Vieira et al., 2023; Akhoondi et al., 2024). Also, increasing mental health literacy and reducing public stigma through community-based programs, health worker training, and media campaigns (Semrau et al., 2024) are vital for improving early detection and access to treatment particularly given the negative correlation between mental health knowledge and stigma (Waghjale et al., 2024). Creating a more inclusive and accessible mental health environment will certainly involve overcoming cultural taboos and enhance mental healthcare (Gurung et al., 2024; Chebet, 2024).

Conclusion

The interplay between culture, gender, and religion plays a major role in defining the experiences of rural Indian women with sexual obsession. The present case series demonstrates how the manifestations of sexual obsessions are influenced by socio-demographic factors and cultural norms. Each woman's story reveals its own struggles, including a profound sense of shame and guilt, social isolation, and compulsive behaviours reinforced by religion and culture. This evidence indicates that culture-sensitive assessments and

interventions are needed to target specific challenges these women face. The steps that improve accessibility to care and promote help-seeking behaviour include culturally relevant therapy, improving mental health literacy, and reducing stigma within rural communities. Complexities of sexual obsessions of rural Indian women call for a multifaceted approach, emphasizing empathy and cultural competence and community engagement. Future research should further explore these intersections to develop targeted therapeutic strategies that ultimately improve mental health outcomes and quality of life.

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Conflict of Interest: The authors declare "No conflict of interest".

Availability of Research Data: All the data-collection and questionnaires regarding this research paper are verified and available at the Corresponding Author, **Maddi Bhawna** (bhawnaprabha29@gmail.com).

The Review of Contemporary Scientific and Academic Studies
An International Multidisciplinary Online Journal
www.thercsas.com
ISSN: 2583-1380 Vol. 5 | Issue No. 03 | March 2025 Impact Factor: 6.53

APPENDIX

Declaration of Patient Consent

Consent from the patients have been obtained for the clinical information to be reported in the journal. The patients understand that their full names and initials will not be published and due efforts will be made to conceal their identity. The blank informed consent form is attached below.

Informed Consent

You are invited to participate in a study titled "The Role of Gender and Culture in Shaping the Experience of Sexual Obsessions in Women with Obsessive-Compulsive Disorder: A Case Series." This study aims to explore how gender and cultural factors influence the experience of sexual obsessions in women with Obsessive-Compulsive Disorder (OCD). Your participation will involve sharing details about your symptoms, experiences, and clinical history in a confidential and de-identified manner.

Participation in this research is entirely voluntary. You may choose not to participate or withdraw from the study at any time without any consequences. Your decision will not affect your current or future treatment.

All identifying information will be removed from the case report to protect your privacy. Personally identifiable details like your names or initials will not be disclosed in any reports or publications.

There are no physical risks associated with participating in this study. However, discussing personal experiences may cause emotional distress. If you feel uncomfortable at any point, you may choose to stop or withdraw from the study. While there are no direct benefits, your participation may contribute to a better understanding of OCD and its treatment.

If you have any questions regarding this study, you may contact:

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I affirm that I have read and understood the above information and have had the opportunity to ask questions regarding the study. I understand that my participation is voluntary and that I can withdraw at any time without any consequences. I agree to participate in this study and provide consent for my anonymized case details to be used for research purposes.

Participant Name: _____

Participant Signature: _____

Date: _____