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Quality of Life and Psychosocial Impairment in Obsessive-Compulsive Disorder: The Differential Impact of Sexual and Religious Obsessions

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ABSTRACT

Obsessive-Compulsive Disorder (OCD) is a chronic psychiatric condition marked by intrusive thoughts (obsessions) and repetitive behaviours (compulsions) that significantly impair functioning. Among its subtypes, sexual and religious obsessions are often underreported due to stigma and guilt. These obsessions may uniquely affect emotional well-being, leading to psychosocial impairment and reduced QOL. Understanding their clinical impact is critical for developing targeted interventions.

Aim: This study aimed to examine the differential impact of sexual and religious obsessions on clinical correlates (anxiety and depression) and quality of life (QOL) among individuals with Obsessive-Compulsive Disorder (OCD), while also exploring the mediating and moderating roles of these variables.

Methodology: A cross-sectional study was conducted with 100 OCD patients diagnosed per DSM-5 criteria. Standardised scales, including the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Hospital Anxiety and Depression Scale (HADS), and WHO Quality of Life-BREF (WHOQOL-BREF) were used to measure OCD severity, clinical correlates, and QOL. Structural Equation Modelling (SEM), ANOVA, and moderation analysis were applied using SPSS and AMOS software to assess the relationships and effects among variables.

Findings and Results: Moderation analysis revealed that quality of life buffered the impact of religious obsessions on OCD severity ($\beta = -0.350$, $p = .008$), but had no significant moderating effect on sexual obsessions. Additionally, ANOVA results indicated that individuals with sexual obsessions, especially when combined with religious obsessions, reported significantly lower QOL scores across physical, psychological, and social domains ($p = .009$). Religious obsessions alone were associated with comparatively better QOL.

Suggestions: The findings underscore the need for differentiated and targeted treatment approaches. While interventions for religious obsessions should focus on enhancing QOL, sexual obsessions require stigma-reduction strategies, identity-focused therapy, and culturally sensitive psychoeducation. Incorporating Maslow's hierarchy of needs and the PERMA model may offer a holistic framework to improve psychological resilience and well-being.

Keywords: *Obsessive-Compulsive Disorder (OCD), Sexual Obsessions, Religious Obsessions, Quality of Life (QOL), Anxiety, Depression, Moderation.*

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1. INTRODUCTION

Quality of life (QOl) is a term that refers to the well-being of a community or an individual in terms of both positive and negative aspects of their existence at a certain period. For instance, typical aspects of quality of life (QOL) include one's *physical, mental, and spiritual health, relationships, level of education, workplace, social standing, wealth, sense of security and safety, freedom, decision-making autonomy, social connection, and physical surroundings* (Teoli & Bhardwaj, 2022).

1.1 Struggling OCD sufferers go through in their day-to-day life

OCD may have a variety of effects on individuals. Some people may struggle to leave the house or carry out daily tasks because they spend many days fulfilling numerous compulsions. Others can appear to be handling daily life, but are experiencing a great deal of sadness due to obsessive thinking. Some OCD sufferers may carry out their rituals and compulsions covertly or come up with justifications to avoid social engagement 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).

OCD is widely recognised as a neuropsychiatric disease. Obsessive-compulsive disorder (OCD) is a prevalent, chronic condition that leads to significant impairment worldwide (Stein et al., 2019). 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). 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 understands that their obsessive ideas are untrue, yet they nonetheless struggle to let go of these beliefs or cease their compulsive behaviours.

1.2 Obsessive-Compulsive Disorder and Its Related Disorders

OCD may also develop due to other mental health conditions the person is dealing with. 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). 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). 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).

1.3 Sexual Obsessions in OCD and Their Impact on Quality of Life

Sexual obsessions in OCD are intrusive, unwanted, and distressing thoughts or images of a sexual nature, such as fears of being a pedophile, committing rape, or having homosexual desires despite evidence to the contrary. These thoughts are ego-dystonic, meaning they are inconsistent with the person's values and cause intense anxiety, shame, and self-disgust (Kuty-Pachecka, 2021; Ehmke & Bubrick, 2021; Hart, 2020). Unlike sexual fantasies, they are not pleasurable and are often misdiagnosed. Around 6% to 24% of individuals with OCD may experience these obsessions (Kunde, 2022).

These obsessions significantly impair quality of life, as sufferers may isolate themselves, avoid relationships, or engage in compulsive behaviours like reassurance-seeking or avoidance to reduce anxiety. The persistent distress and fear of acting on these thoughts, though unfounded, can lead to depression, social withdrawal, and diminished overall well-being (Kunde, 2022; Ehmke & Bubrick, 2021).

1.4 Religious Obsessions in OCD and Their Impact on Quality of Life

Religious obsessions, also known as scrupulosity, are a subtype of OCD characterised by intrusive, distressing thoughts related to religious or moral issues. These include fears of blasphemy, sinning, divine punishment, and compulsive behaviours such as excessive praying, confessing, or seeking reassurance (Kazmi, 2019; Bilekli & Inozu, 2018). Individuals with intrinsic religiosity live by their faith as a central life purpose, whereas extrinsically religious individuals may use religion instrumentally (Allport & Ross, 1967; Kazmi, 2019). Research shows that religiosity, especially when rigid, along with guilt and magical thinking, significantly correlates with OCD symptoms (Rakesh et al., 2021; Hackney & Sanders, 2003).

Religious obsessions severely impair quality of life, as sufferers experience chronic guilt, shame, anxiety, and fear of moral or spiritual failure. These symptoms can lead to social withdrawal, impaired functioning, and heightened emotional distress, particularly in culturally or religiously rigid contexts (Bilekli & Inozu, 2018; Rakesh et al., 2021). Poor insight and neuroticism can further worsen symptom severity and hinder treatment outcomes (Bayırlı, 2013).

1.5 Theory related to the quality of life among OCD patients

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). Which includes *psychological needs, Security and safety needs, and social needs for self-esteem:* Those

who lack self-esteem and the respect of others, on the other hand, may develop feelings of inferiority. As a result, people may have a reduced quality of life during this time. *Needs for Self-Actualisation:* Self-actualisation needs are at the very top of Maslow's hierarchy. Self-actualising people are self-aware, concerned with improving themselves, less concerned with the views of others, and engaged 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). It is believed that improvements in QOL are followed by hierarchical changes in these societal structures (Sirgy, 1986). So, suppose we wish to enhance the quality of life of persons with OCD. In that case, it is critical to keep Maslow's hierarchy of needs in mind while diagnosing OCD, since these needs can interrelate and can affect the quality of life among OCD patients.

1.6 How Obsessive-compulsive disorder affects the Quality of life of people Suffering from OCD

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). 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.

In a hospital-based, longitudinal, descriptive study of 100 obsessive-compulsive disorder (OCD) patients. Based on the data, 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, the severity of the disease had a substantial negative association with overall Quality of life. 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 findings, the stigma and severity of OCD considerably influence the quality of life. Stigma reduction and adequate severity control should be basic components of OCD treatment (Garg et al., 2023).

1.7 Social support, coping and interpersonal behaviour among OCD sufferers

(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, 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. (Stein et al., 2019) investigated that patients with OCD have a significantly lower quality of life than healthy controls in various aspects such as work, family, and social activities, 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 OCD include serotonin reuptake inhibitors, cognitive behavioural therapy,

and neurosurgery, particularly for those with severe symptoms. By merging global mental health and translational neuroscience approaches, knowledge and treatment outcomes for OCD could be enhanced.

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 QOL was poor and relationship satisfaction was modest. A lower QOL was linked to a lack of paid jobs and more severe co-morbid depression and anxiety symptoms. Fewer checking symptoms, more severe co-morbid depression symptoms, and the feeling that partners lacked emotional support or were annoyed were related to worse relationship satisfaction. The results and recommendations indicated that, in order to increase QOL and relationship satisfaction, therapy should concentrate on the perceived contact with partners, and co-morbidity, including the patient's capacity to work (Remmerswaal et al., 2016).

1.8 Obsessive-compulsive disorder and Disability

(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 findings 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 the 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).

Research Gap

Despite global evidence showing that individuals with OCD experience significantly reduced quality of life in areas like work, family, and social interactions (Stein et al., 2019), there is a lack of in-depth research in India—particularly on underexplored symptoms such as sexual obsessions (Garg et al., 2023). Although sexuality is a key dimension of well-being, it is frequently overlooked by clinicians. Indian studies rarely examine how factors like stigma, severity of illness, and lack of insight affect quality of life in OCD (Garg et al., 2023), even though people with OCD often hide their symptoms due to shame or fear of judgment. This gap is further widened by limited awareness among both the general public and mental health professionals.

Obsessions in OCD lead to chronic anxiety, guilt, and functional impairment, significantly lowering life satisfaction (Williams & Farris, 2011). Yet, clinicians are often undertrained to recognise these effects, leading to misdiagnosis or neglect. Given these gaps, a culturally sensitive and comprehensive approach is urgently needed to explore how factors like anxiety, depression, stigma, and lack of support impact the quality of life of OCD patients in India.

2. METHODOLOGY

2.1 Research Question

Table 1. Research questions with significance

S.No.	Research Question	Significance
1	What is the moderating effect of quality of life on the relationship between sexual and religious obsessions and overall functioning in individuals with obsessive-compulsive disorder (OCD)?	This question aims to explore whether quality of life influences how sexual and religious obsessions affect a person's ability to function daily. Understanding this moderating effect can guide interventions that aim not only to reduce obsessions but also to enhance life quality, which may buffer against impairment.
2	How does the presence of sexual and religious obsessions affect the quality of life among individuals diagnosed with OCD?	By examining the direct impact of sexual and religious obsessions on quality of life, this question highlights the emotional and social burden of these

		specific OCD themes. The findings can inform targeted therapies and reduce treatment gaps in under-recognized symptom areas.
3	How are clinical correlates—such as anxiety, depression, and insight—associated with the quality of life in individuals with OCD?	This question investigates how psychological factors contribute to quality of life in OCD patients. Insights from this analysis can help clinicians assess and address co-occurring symptoms and cognitive patterns that worsen quality of life, leading to more comprehensive treatment plans.

2.1 Research Design

The present study utilised a cross-sectional research design. Primary data were collected through standardised psychological instruments, including validated questionnaires and inventories. Secondary data, such as hospital records, were used to corroborate and contextualise the findings obtained from primary sources.

2.2 Sampling Method

Participants were selected using purposive sampling from the Ashoka Neuro Psychiatric Hospital & Addiction Centre in Jalandhar, Punjab, which serves individuals from varied socio-demographic backgrounds. The sample comprised 100 participants, aged 18 to 40 years, who had been previously diagnosed with Obsessive-Compulsive Disorder (OCD) according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) or International Classification of Diseases, Tenth Revision (ICD-10; World Health Organization, 1992), as recorded in hospital documentation.

2.3 Inclusion Criteria

Participants were included in the study based on the following criteria:

- Age 18 years and above
- Primary diagnosis of OCD according to DSM-5 or ICD-10
- Registration as a patient in the psychiatric outpatient department
- Inclusion of both male and female participants
- Minimum educational qualification of the primary level

2.4 Exclusion Criteria

Exclusion criteria were as follows:

- Age below 18 years
- Illiterate individuals or those with less than a primary education
- Presence or suspicion of organic mental illness
- Inability to understand the study procedures or provide informed consent

2.5 Tools

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. 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 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.

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 0.62-0.86, and discriminant validity is good.

2.6 The Procedure for Screening the Sample

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 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 explained 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, 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 2.1,

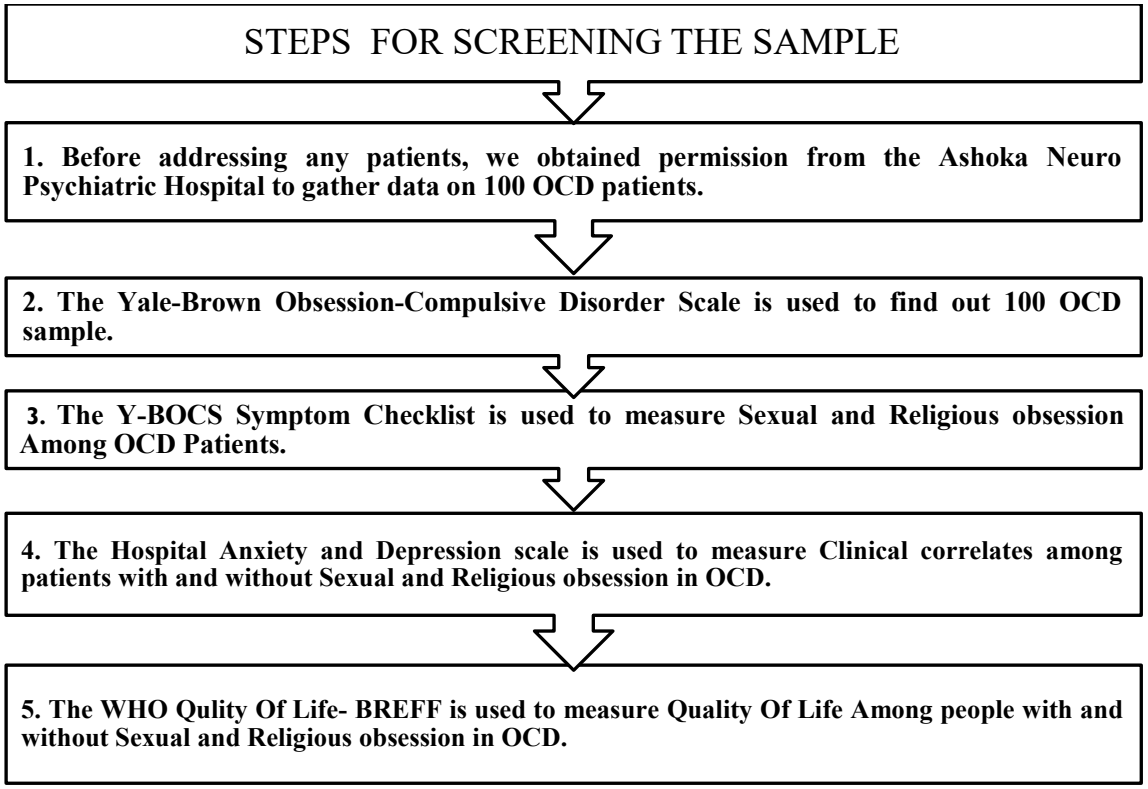

Figure 2.1: The steps for screening the sample

2.7 Data Analysis

The data were analysed using IBM SPSS (Version 23) and AMOS for structural equation modelling. For the first research question, examining the moderating effect of quality of life**,** moderation analysis was conducted using AMOS to test interaction effects within a structural model framework. To address the second research question—how sexual and religious obsessions affect quality of life in individuals with OCD—descriptive statistics and one-way ANOVA were applied to assess differences in quality of life across varying levels of obsession severity. For the third research question, which explored the associations between clinical correlates (anxiety, depression, insight) and quality of life**,** Pearson's correlation analysis was used to identify the strength and direction of relationships among the variables.

3. RESULTS

RQ: 1 What is the moderating effect of quality of life on the relationship between sexual and religious obsessions and overall functioning in individuals with obsessive-compulsive disorder (OCD)?

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.

Figure 3.1: *AMOS Drawing of the Moderation Effect Model*

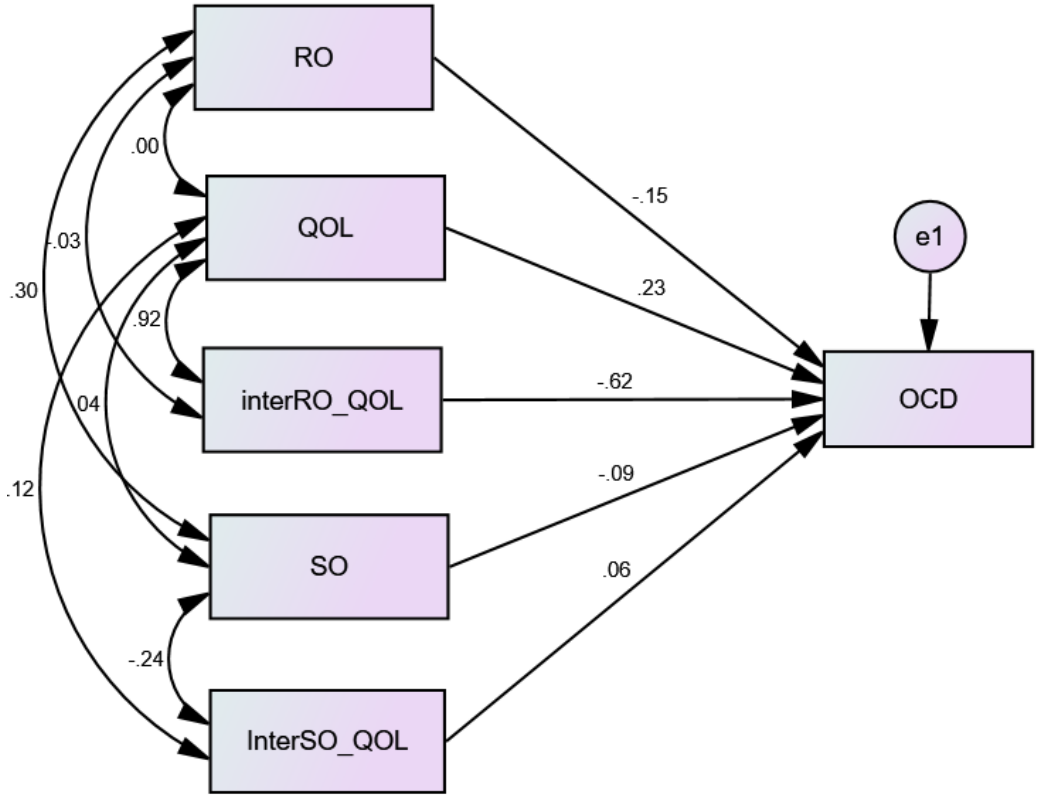

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Table 3.1 : Moderation Analysis

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

Table 3.1 and Figure 3.1 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 (β = -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 (β = 0.084, p = .524), implying that QOL does not moderate the relationship between sexual obsessions and OCD symptoms.

Figure 3.2: Simple Slope Graph for the Moderation Effect of Quality of Life on the Relationship Between Religious Obsessions and OCD Severity

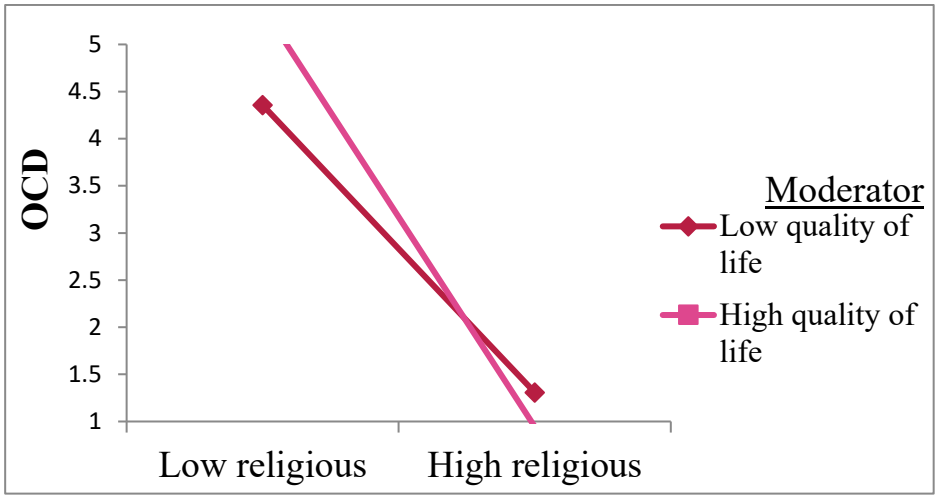

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Figure 3.2 illustrates the moderation effect of Quality of Life (QOL) on the relationship between Religious Obsessions and OCD severity. The steeper slope for high QOL suggests that as religious obsessions increase, OCD symptoms decrease more sharply 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 3.4: Simple Slope Graph for the Moderation Effect of Quality of Life on the Relationship Between Sexual Obsessions and OCD Severity

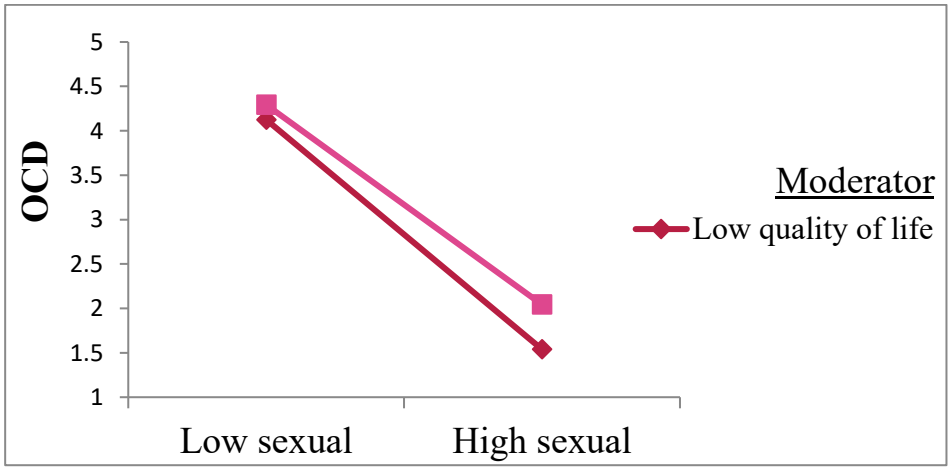

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Figure 4.5.3 presents a simple slope graph depicting the relationship between sexual obsessions, OCD severity, and the moderating role of quality of life (QOL). The results indicate that QOL does not significantly moderate the relationship between 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 3.2: 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 3.2 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.

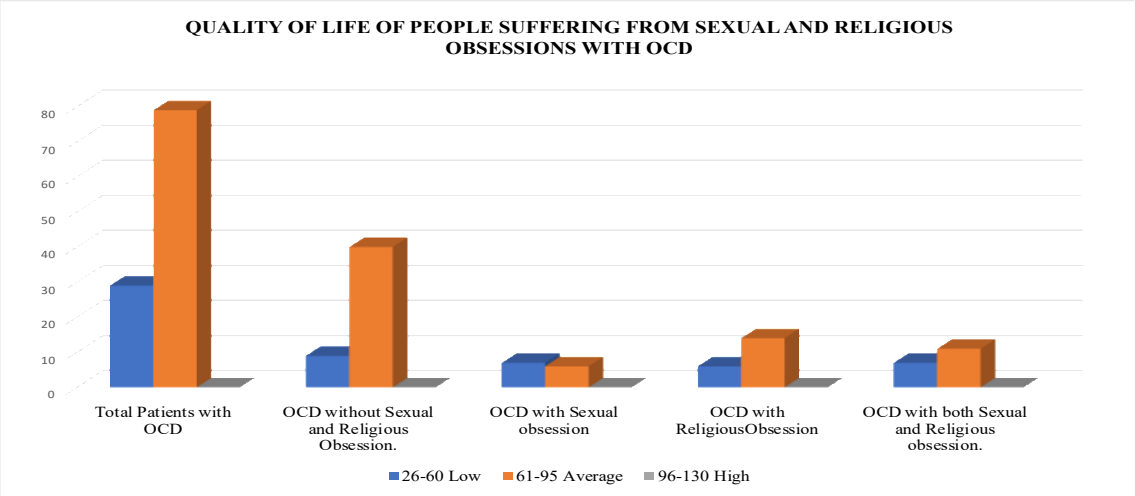
RQ: 2 How does the presence of sexual and religious obsessions affect the quality of life among individuals diagnosed with OCD?

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).

Table 3.3 : 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 3.5 : Bar chart showing the Quality of life of people suffering from OCD



Source: own data

Table 3.3 and Figure 3.5 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 3.4 : 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 3.4 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 3.5 : Descriptive Statistics for Overall Quality of Life with Skewness and Kurtosis

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

Table 3.5 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 3.6 : Levene's Test for Homogeneity of Variance

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

Table 3.6 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 3.7 *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 3.7 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 3.8 : *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 3.8 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 3.9: 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 Religious obsessions	-6.83	0.093
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 3.9, 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.

RQ 3 How are clinical correlates, such as anxiety, depression, and insight, associated with the quality of life in individuals 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.

Table 3.10 : 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 3.10 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, emphasising 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. DISCUSSION

The study demonstrates a nuanced relationship between obsession types, quality of life (QOL), and OCD severity. Moderation analysis revealed that QOL significantly buffered the effect of religious obsessions on OCD severity, with individuals reporting higher QOL experiencing a sharper decline in symptom severity as religious obsessions increased. This suggests that QOL acts as a protective factor, potentially due to access to adaptive coping mechanisms such as spiritual coping, social support, and emotional resilience (Gordon, 2002). These findings align with the PERMA model of well-being, which highlights the importance of positive emotions, meaning, and relationships in enhancing psychological health (Seligman, 2012), and with Maslow's Hierarchy of Needs, which proposes that individuals with fulfilled safety and belonging needs may better manage psychological stressors (Maslow, 1943; Cherry, 2022).

In contrast, sexual obsessions were not significantly moderated by QOL, indicating that the distress associated with these obsessions persists regardless of overall well-being. The absence of significant interaction may reflect the deeply internalised shame, guilt, and identity conflict that sexual obsessions provoke, which are less responsive to external protective factors like QOL (Boger et al., 2020; Siev et al., 2011). This is further supported by findings that QOL did not mitigate OCD severity in individuals with sexual obsessions, pointing to the need for more targeted therapeutic approaches.

Moreover, sexual obsessions were not significantly associated with anxiety or depression, consistent with prior research emphasising that their emotional burden is uniquely tied to stigma and self-identity rather than classical mood symptoms (Abramowitz et al., 2025; Nicolini et al., 2017; Williams et al., 2011). These obsessions may instead lead to social withdrawal and avoidance behaviours rather than diagnosable affective disorders (Abramowitz & Jacoby, 2014).

Quality of life outcomes varied significantly among OCD subgroups. Patients with sexual obsessions—alone or alongside religious obsessions—reported the lowest QOL across physical, psychological, and social domains (Pozza et al., 2020; Żerdziński et al., 2022). In contrast, those with religious obsessions alone experienced relatively better QOL, reinforcing the importance of obsession content in shaping patient outcomes (Singh et al., 2022). These patterns align with Maslow's framework, suggesting that unresolved needs related to safety, social belonging, and esteem may hinder overall well-being (Maslow, 1943), and with the PERMA model, which emphasises engagement, social support, and meaning as contributors to resilience (Seligman, 2012).

Overall, the findings underscore the differential psychological burden of sexual and religious obsessions in OCD. While QOL appears to buffer the impact of religious obsessions, it offers limited protection against the distress associated with sexual obsessions, which may require specialised cognitive, behavioural, and stigma-focused interventions.

5. LIMITATIONS

- The cross-sectional design limits causal interpretations between obsessions, quality of life, and clinical correlates.
- The sample size (N = 100) from a single psychiatric hospital limits generalisability to other populations.
- Self-report measures may be influenced by social desirability bias, especially due to the sensitive nature of sexual and religious obsessions.
- The study did not control for medication use, duration of illness, or treatment history, which could affect outcomes.
- Other OCD subtypes were not explored, and variations in religiosity or religious affiliation were not analysed.

6. CONCLUSION

This study highlights the complex and differential impact of sexual and religious obsessions on OCD severity and quality of life (QOL). Quality of life emerged as a partial moderator—buffering the effect of religious obsessions but not sexual obsessions—suggesting that enhanced well-being can reduce distress in scrupulosity. In contrast, sexual obsessions remain resistant due to deep-rooted shame and stigma. Additionally, anxiety and depression were found to significantly impair QOL, reinforcing their role as key clinical correlates in OCD. These findings underscore the need for personalised, obsession-specific interventions—such as cognitive-behavioural therapy, stigma-reduction strategies, and holistic models like Maslow's hierarchy and the PERMA framework—to improve both symptom severity and overall well-being in individuals with OCD.

Author's Contribution

The author was actively involved in all phases of the research process, including conceptualisation, study design, data collection, and statistical analysis. Additionally, the author interpreted the results, prepared the initial manuscript draft, and conducted critical revisions to enhance its intellectual quality. Final approval of the manuscript was also granted by the author, ensuring the accuracy and integrity of the work.

Research Conflicts

The authors of this research claim to be free of any conflicts of interest.

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Ethical Consideration

All individuals who participated in this study were clinically diagnosed with obsessive-compulsive disorder (OCD), specifically characterised by sexual and religious obsessions. The research was conducted by the ethical standards of the Institutional Ethical Committee (IEC) of Lovely Professional University (LPU), which approved 12/09/2024 (Ref: LPU/IEC-LPU/2024/3/10).

Before participation, each individual was fully informed about the purpose and scope of the study, and written informed consent was obtained. Participants were assured that their responses would remain confidential, and all data were anonymised to protect their identities. The information collected was used solely for academic research, in full compliance with ethical guidelines related to privacy and data protection.

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