CASE REPORT

A Case of Sexual Obsessions in Obsessive-Compulsive Disorder: The Role of Childhood Sexual Trauma

Halimah Hanizam[1], Tengku Mohd Saifuddin Tengku Kamarulbahri[2]

[1] Department of Psychiatry, Kulliyyah Of Medicine, International Islamic University Malaysia, Bandar Indera Mahkota, 25200 Kuantan, Pahang Darul Makmur, Malaysia.
[2] Department of Psychiatry and Mental Health, Faculty of Medicine, Universiti Sultan Zainal Abidin, 20400, Kuala Terengganu, Terengganu, Malaysia

ABSTRACT

Sexual obsessions represent a unique and distressing symptom dimension in obsessive-compulsive disorder (OCD). These obsessions are particularly challenging to treat due to their sensitive nature and their association with past traumatic experiences. We report the case of a 27-year-old woman who presented with obsessive-compulsive disorder (OCD) features for approximately four years, primarily revolving around themes of cleanliness, safety and sexual themes. Her symptoms include intrusive sexual thoughts, which she found repugnant and anxiety-provoking. Further research is needed to clarify the mechanisms linking trauma to OCD and to refine interventions that address the unique needs of this population.
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Corresponding Author:
Tengku Mohd Saifuddin Tengku Kamarulbahri,MMed (Psychiatry)
Email: tgsaifuddin@unisza.edu.my
Tel: +609-627 5546

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a prevalent and debilitating mental health condition, impacting approximately 1–3% of the general population (1). Childhood sexual abuse has been identified as a significant risk factor for the development of OCD, with survivors often reporting a higher frequency of sexual content intrusions (2, 3). These intrusions are characterised by repetitive, unsolicited, intrusive sexual thoughts and images, which cause marked anxiety or distress, a hallmark feature of OCD in individuals with a history of sexual trauma (4).

We report the case of a 27-year-old woman who presented with OCD features for approximately four years, primarily revolving around themes of sexual themes. This case report aims to illustrate how sexual obsessions can manifest in OCD, particularly in the context of childhood sexual trauma, and to highlight treatment strategies.

CASE REPORT

A 27-year-old woman, single and unemployed, presented with obsessive-compulsive disorder (OCD) features for approximately four years, primarily revolving around themes of sexual, cleanliness and safety. She feels compelled to perform certain rituals to alleviate her anxiety. Additionally, she harbours an obsession with the theme of sexual abuse. The patient expressed a fear that if she were to die, no one would care for her mother, and she is also anxious about the potential for men to sexually harm her mother.

The patient has endured persistent and intrusive mental images for many years, primarily involving her mother in sexually compromising or abusive scenarios. Since her adolescence, she frequently visualizes her mother engaging in sexual activity with other men or being subjected to sexual assault and rape. These vivid images occur involuntarily and often intrude into her mind

multiple times throughout the day, sometimes several times an hour, especially during periods of heightened anxiety or stress.

Upon further exploration, it was revealed that the patient experienced a critical incident involving social media. She encountered a Twitter thread discussing a man who was previously known for being kind toward women. However, his ex-girlfriend later disclosed that he had engaged in various forms of sexual harm, including coercing women into sexual activities and disrespecting them. Although she initially moved past the story, the impact of reading it instilled a profound fear for her mother's safety. Afterwards, she felt an urgent need to check on her mother's well-being and asked her if she was "okay." While she does not believe there is any actual issue, the compulsion to ensure her mother's safety and sexual experience intensified to the point where she inhibited her parents from sleeping together, fearing her mother might be sexually assaulted.

These symptoms have led to significant disruptions in her interpersonal, social, and occupational functioning. Prior to the escalation of her symptoms, the patient was able to function at a moderate level. She completed her education and engaged in occasional part-time work, though she often found it difficult to maintain long-term employment due to underlying anxiety and perfectionistic tendencies. Socially, she maintained a small circle of friends and participated in some family activities. Over time, however, her intrusive thoughts and compulsive behaviours became more intense. This led to progressive social withdrawal and a complete inability to sustain work. Despite experiencing mounting psychological distress for several years, she did not seek psychiatric treatment. She remained cognitively aware that her obsessions and compulsions were irrational, yet felt overwhelmed and unable to resist them. Furthermore, she has developed depressive and anxiety symptoms as a consequence of her OCD. At times, she has resorted to self-harm and suicidal gestures, which necessitated hospital admission.

She was raised by authoritarian parents who were verbally abusive and used corporal punishment. Her mother had an anxiety disorder and was treated with medication, but subsequently defaulted. She also had a history of being molested by her cousin's husband when she was 14 years old, and she refused to be in a relationship due to this. Moreover, she was bullied and body-shamed in school.

The mental state revealed a young lady with a moderate body built. She appeared anxious with obsessional thoughts involving a sexual theme. She had no delusions, no hallucinations and thought insertion. Her form of thought was normal. She denied suicidal thoughts.

Pharmacologically, she was initiated on sertraline 50 mg daily, which was gradually titrated to 200 mg over eight weeks. Due to only a partial response and persistent symptoms, olanzapine 5 mg was added in the following month. Olanzapine was added as an augmenting agent, which is consistent with second-line treatment recommendations outlined in the Maudsley Prescribing Guidelines. Additionally, she had poor oral intake and significant sleep disturbances, which further supported the use of olanzapine to address these associated symptoms.

The patient completed eight weekly sessions of cognitive-behavioural therapy (CBT), each lasting about an hour. Treatment focused on exposure and response prevention and cognitive restructuring. Initial sessions provided psychoeducation on OCD and intrusive thoughts, helping her differentiate between unwanted obsessions and actual intent. Gradual exposure to feared thoughts (particularly around her mother's safety) was introduced, alongside strategies to resist compulsive reassurance-seeking. Therapy targeted distorted beliefs such as inflated responsibility and overestimation of harm. Progress was monitored through clinical observation and self-reports, with notable reductions in the frequency and intensity of obsessions, decreased distress, and improved tolerance of intrusive thoughts without engaging in compulsions.

DISCUSSION

Sexual obsessions in OCD are defined by the presence of intrusive, unsolicited sexual thoughts and imagery that cause significant distress to the individual (4). Such obsessions are particularly common in adolescents with OCD, with an estimated prevalence of 16.8% among OCD patients (5). Other studies indicate that approximately 25% of individuals with OCD experience sexual intrusive thoughts and that these individuals often present with an earlier onset of OCD symptoms compared to those without such obsessions (3).

A critical distinction in sexual obsessions is their unpleasant and distressing nature, contrasting with sexual fantasies or desires, which are generally experienced as pleasurable. Compulsions in this context serve to alleviate anxiety rather than to provide gratification. The distress associated with sexual obsessions stems not only from fear of consequences but also from frustration regarding the irrationality of the compulsions and their time-consuming nature (4). The cognitive theory of OCD provides insights into the mechanisms underpinning sexual obsessions. It suggests that individuals with obsessional intrusive thoughts differ from those without in their exaggerated sense of responsibility for preventing perceived negative outcomes. This leads to heightened appraisals of the significance and controllability of these intrusions, perpetuating the distress and compulsive responses (3). This case also raises the differential consideration of Compulsive Sexual Behavior Disorder (CSBD). However, unlike CSBD, which involves

repetitive and uncontrolled sexual behaviours often experienced as ego-syntonic, this patient's symptoms were clearly ego-dystonic, distressing, and aligned more with obsessive fears than impulsive drives.

Genetic predisposition plays a critical role in the aetiology of OCD; however, environmental factors, particularly childhood trauma, significantly influence its development. Traumatic experiences such as physical violence and sexual abuse are strongly associated with OCD (4). Studies have demonstrated a link between childhood sexual abuse and the severity of OCD symptoms, with trauma exposure predicting poorer treatment outcomes and exacerbating obsessive-compulsive symptoms (1, 2).

OCD resulting from sexual trauma may manifest with explicit sexual imagery, a phenomenon that remains underexplored (2). Specific traumatic experiences, including sexual abuse, are uniquely associated with intrusive sexual thoughts and heightened cognitive dysfunction (1, 3). Survivors of sexual trauma not only report more severe intrusions but also experience greater distress and display more dysfunctional cognitive appraisals related to these intrusions (3). This is consistent with findings that trauma-induced chronic anxiety fosters a maladaptive cognitive style characterized by exaggerated threat appraisals and rigid belief systems (3).

Treating sexual obsessions in OCD presents unique challenges, particularly in adolescents. There is limited guidance on conducting exposure and response prevention (ERP) therapy sensitively for this subgroup (5). ERP remains one of the most effective therapeutic approaches for OCD, particularly for mitigating compulsive behaviors (4). Imagery-based techniques have also shown promise in reducing the intensity of sexual obsessions (5). Cognitive-behavioral therapy (CBT) for OCD, including imagery-based approaches, has demonstrated neurobiological efficacy, such as reductions in glucose metabolism in the caudate nucleus among participants (4). However, the nuanced relationship between trauma exposure and OCD underscores the need for tailored interventions. A deeper understanding of these associations is essential for optimizing treatment outcomes, especially given that trauma may worsen OCD symptoms and predict poorer responses to conventional therapies (1).

CONCLUSION

Sexual obsessions in OCD are complex phenomena shaped by the interaction between biological and environmental factors, including trauma exposure. This case highlights the complex interaction between childhood sexual trauma and the development of sexual obsessions in OCD. Further research is warranted to explore the mechanisms linking trauma to OCD and to optimise interventions for this challenging symptom dimension. In Malaysia, literature on sexual obsessions in OCD is scarce, possibly due to sociocultural taboos surrounding discussions of sexuality and trauma. This emphasises the need for culturally sensitive approaches in clinical assessment and intervention.

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