



Obsessive-Compulsive Disorder with Sexual Obsessions and Severe Depressive Episodes with Psychotic Symptoms

Rizky Silvianingrum

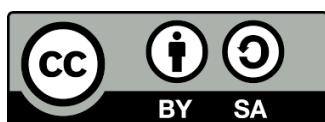
Universitas Hang Tuah, Indonesia
Email: rizkysilvianingrum@gmail.com

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Abstract

Sexual orientation-related obsessions in adolescents with obsessive-compulsive disorder (OCD) may be overlooked when compulsive behaviors intended to neutralize distressing thoughts resemble problematic sexual behavior. Religious guilt and comorbid depression may further complicate diagnostic recognition. This case report aimed to describe the clinical phenomenology, differential diagnosis, management, and short-term clinical course of sexual orientation-related obsessions accompanied by a severe depressive episode with psychotic symptoms. A descriptive clinical assessment was conducted involving a 15-year-old boy through psychiatric interviews, mental status examinations, collateral information from family members, and repeated assessments using the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS). Treatment included sertraline, aripiprazole, psychoeducation, supportive psychotherapy, exposure and response prevention (ERP), and behavioral activation. The patient experienced recurrent, unwanted, ego-dystonic sexual thoughts and engaged in masturbation three to five times daily as a compulsive behavior intended to alleviate anxiety and seek reassurance about his sexual orientation. His CY-BOCS score decreased from 34 at admission to 17 on the fourth day of hospitalization but subsequently increased to 26 at the one-month postdischarge follow-up. Compulsive behaviors persisted, and the patient had not resumed school attendance despite reported adherence to medication. This clinical course suggested that environmental restrictions during hospitalization might have influenced the observed reduction in symptom severity, although a causal relationship could not be established. The case underscored the importance of assessing the psychological function of repetitive behaviors, identifying comorbid depressive symptoms, and evaluating suicide risk. Continued psychiatric follow-up and contextual assessment are essential for monitoring recovery, while the findings from this single case cannot establish treatment effectiveness or be generalized to broader adolescent populations.



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INTRODUCTION

Obsessive-compulsive disorder (OCD) has a lifetime prevalence of approximately 2.3% in the adult population, with many cases beginning during childhood or adolescence (Ruscio et al., 2010). Sexual obsessions represent a recognized symptom dimension of OCD but are among the least frequently disclosed symptoms because of shame, embarrassment, and fear of moral judgment. In clinical samples, sexual obsessions have been reported in approximately 16.8% of individuals with OCD as current symptoms and 26.3% as lifetime symptoms, whereas sexual orientation-related obsessions have been identified in 8% and 11.9% of individuals,

respectively (Williams & Farris, 2011). These findings suggest that sexual orientation-related obsessions are clinically relevant but may remain underrecognized during routine psychiatric assessments.

Sexual orientation-related obsessive-compulsive disorder (SO-OCD) is characterized by recurrent, intrusive, and unwanted doubts about one's sexual orientation that cause significant distress and are often experienced as ego-dystonic. These symptoms must be distinguished from normative sexual identity exploration and uncertainty about sexual orientation. In SO-OCD, the primary clinical concern is the distress associated with persistent uncertainty and compulsive attempts to obtain reassurance rather than the individual's sexual orientation itself. Sexual orientation-related obsessions have been associated with greater psychological distress, functional impairment, and avoidance behaviors than some other OCD symptom dimensions (Williams & Farris, 2011; Williams & Wetterneck, 2019).

Common compulsions associated with SO-OCD include repeated mental checking of emotional or sexual responses, monitoring of genital sensations, reassurance-seeking behaviors, and avoidance of situations or stimuli that trigger obsessional doubts (Osivwemu et al., 2025; Williams & Wetterneck, 2019). Repetitive masturbation performed as a neutralizing ritual to obtain reassurance about one's sexual orientation has received relatively limited attention in the literature. This behavioral manifestation is clinically important because it may superficially resemble problematic sexual behavior and consequently be misinterpreted as compulsive sexual behavior disorder, problematic pornography use, or impaired self-control (Kraus et al., 2018). Differentiating these conditions requires careful assessment of the behavior's underlying motivation, psychological function, and relationship to intrusive obsessive thoughts.

The risk of diagnostic misinterpretation may increase in religious and sociocultural contexts in which patients and their families interpret sexual behaviors primarily through moral or religious frameworks. Perceived discrepancies between personal behavior and moral values have been associated with increased psychological distress and self-perceived addiction, even when the severity of behavioral dysregulation does not necessarily support such interpretations (Grubbs et al., 2019; Grubbs & Perry, 2019). However, published clinical reports specifically addressing SO-OCD among adolescents in Muslim-majority Southeast Asian populations remain limited.

This case report describes an adolescent boy presenting with sexual orientation-related obsessions and repetitive masturbation functioning as a compulsive neutralizing behavior, accompanied by a comorbid severe depressive episode with psychotic symptoms. The report aims to describe the clinical phenomenology distinguishing OCD-related compulsions from compulsive sexual behavior, highlight relevant diagnostic considerations, and discuss their implications for psychiatric assessment and management in adolescents.

CASE REPORT

A 15-year-old boy, a high school student, Javanese and Muslim, was admitted to the psychiatric ward of a hospital in Surabaya with the main complaint of the appearance of unwanted recurring thoughts of same-sex sexual themes since nine months before treatment.

The phenomenology of obsession. These thoughts and fantasies appear suddenly, repeatedly, and unwanted. The patient realizes that the thought comes from himself, feels that it is contrary to his personal values and religious beliefs, and tries to fight it without success.

Each appearance is accompanied by anxiety and doubts about his sexual orientation. Thoughts can arise during activities at school or while driving, and aggravate when the patient is alone at home. On the psychosexual history search, the patient stated that his sexual attraction was to the opposite sex and only accessed heterosexual content. He denied that same-sex attraction or fantasies were intentional or pleasurable. The first exposure to sexual content occurred at the age of about 13 through peers. There was no history of sexual abuse or forced sexual exposure.

Phenomenology of compulsions. To relieve the anxiety, the patient masturbates with heterosexual visual stimulus three to five times per day. According to the patient, this behavior has two functions, namely neutralizing intrusive thoughts and convincing themselves of their sexual orientation. The patient emphasized that the behavior was not done to obtain sexual satisfaction, but solely to relieve tension and doubt. The relief obtained was temporary and immediately followed by feelings of guilt because it was considered contrary to his religious values. If he did not do so, the patient felt increased anxiety, anxiety, and difficulty concentrating. Several times the patient tried to stop the behavior but failed due to frustration. No similar behavior was found in public places or injuries to the genitals.

Comorbidity depressive syndrome. At the same time frame, the patient experiences a feeling of emptiness and flatness that persists almost every day, reduced interest in activities that were previously enjoyed, feelings of uselessness, pessimistic outlook on the future, easy fatigue, sleep disturbances, social withdrawal, and decreased academic function to the point of frequent school absences. The use of mobile phones reaches more than 12 hours per day. The patient believes that his emotional complaints are caused by his masturbation habits.

Risk episodes. About eight months before treatment, the patient briefly took a knife and pointed it at his wrist. At that moment a voice was heard telling him to end his life. The action was not continued due to religious considerations and remembering his mother. Auditory hallucinations occurred only during the episode and did not recur.

Previous treatment history. Six months before treatment, the patient had been treated at another hospital and was diagnosed with severe depression with psychotic symptoms and GOK. The patient did not take medication regularly and then stopped treatment because he experienced low back pain which he feared was due to an overdose. From the anamnesis, it is known that the patient's fluid intake was very poor, about half a glass per day.

Premorbid and psychosocial history. The patient's growth and development progresses according to his age. Before his illness, the patient was a teenager with good functioning: he had been the head of a student organization and a member of the flag-raising force at school, and was active in religious activities. The biological father died of a stroke when the patient was 9 years old. The patient's mother had been married four times; the fourth marriage took place when the patient was 14 years old, with a stepfather of about 70 years old who did not live at home and had hearing impairment so that interaction was limited. The patient attributed his behavior to loneliness because he was often alone at home. There was no history of mental disorders in the family. The patient smoked one to three cigarettes per day; a history of alcohol and other psychoactive substances was denied.

Examination. Internal and neurological status within normal limits. In the examination of mental status, appearance according to age was obtained, cooperative attitude with avoidant eye contact, depressive mood and affectation with maintained harmony, spontaneous speech with a quiet volume, coherent flow of thought, and no delusions. The content of thought was

dominated by obsessions with the theme of sexual orientation that was egodystonic. Cognitive function and orientation were good. Sixth degree examination.

Instruments. The Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) was used to assess severity (Inozu et al., 2012; Scahill et al., 1997). The assessment focused on sexual orientation-themed obsessions and masturbation compulsions as an attempt to neutralize (Storch et al., 2004). The assessment was conducted at three time points, namely at admission to care, on the fourth day of treatment, and at an outpatient visit one month after discharge. Serial scores are presented in Table 2.

Diagnosis. Based on the DSM-5-TR, patients meet the criteria for obsessive-compulsive disorder with good judgment, as well as single-episode, severe major depressive disorder, with mood-compatible psychotic symptoms (Association, 2022). Based on PPDGJ-III, this case is classified as F42.2 obsessive-compulsive disorder of mixed obsessive thoughts and obsessive actions and F32.2 severe depressive episodes with psychotic symptoms (Maslim, n.d.). Organic mental disorders are ruled out on the basis of normal physical and neurological examinations and the absence of decreased consciousness or cognitive deficits. The Global Assessment of Functioning at admission is in the range of 31 to 40 and at discharge in the range of 61 to 70.

Management. Pharmacotherapy administered until discharge consisted of sertraline 50 mg single dose in the morning and aripiprazole 2.5 mg twice daily. The dose of sertraline was below the recommended therapeutic range for GOK. The selection of a low initial dose was based on two considerations. First, the patient's previous history of discontinuation of treatment was triggered by the patient's belief that the physical complaints he experienced were a sign of overdose, thus rebuilding trust in the drug became a priority to prevent relapse. Second, adolescents with a history of suicidal ideation demanded strict monitoring of activation symptoms at the beginning of therapy. Aripiprazole was given on the basis of psychotic symptoms in depressive episodes, as well as being a commonly used agent as an augmentation in refractory GOK (Bloch et al., 2006). Sertraline titration is planned to be continued in outpatient services.

Nonpharmacological interventions begin with psychoeducation to patients and families about the nature of intrusive thoughts, obsession-compulsive cycles, medication adherence, and prognosis. To families, explanations are given in general without revealing the specific content of the patient's intrusive thoughts in order to maintain confidentiality. Families are specifically educated not to provide repeated calming to the patient's doubts, as this actually reinforces the cycle of symptoms.

Supportive therapy is provided to facilitate the expression of emotions, build an understanding of the relationship between thoughts, emotions, and behaviors, and increase expectations for improvement. Cognitive behavioral therapy with exposure and response prevention (ERP) techniques is provided with the target of response prevention including masturbation as an effort to neutralize, checking one's own body responses, and repeated search for calming related to sexual orientation. Behavioral activation is carried out through the preparation of a structured daily activity schedule to reduce free time and loneliness. Stimulus management includes limiting the use of gadgets and access to pornographic content that acts as a means of implementing compulsions, as well as environmental arrangements to reduce solitary time that is the trigger.

Outputs. The patient was discharged on the twelfth day of treatment with a Global Assessment of Functioning in the range of 61 to 70, increasing from 31 to 40 at admission, accompanied by an outpatient control plan to continue medication titration and ERP sessions. The reassessment was carried out at the outpatient visit one month after discharge. At the visit, the patient appeared calm and cooperative with directed communication, and reported good medication adherence. However, the patient had not returned to school due to anxiety and still spent most of his time alone at home, while masturbation as an attempt to neutralize was still ongoing. The CY-BOCS score at the visit was 26, lower than the initial score of 34 but higher than the assessment of the fourth day of treatment of 17.

Table 1. Chronology of the course of the disease

Time	Clinical events
Age ± 13 years old	First exposure to sexual content through peers
9 months before treatment	The onset of intrusive thoughts with the theme of sexual orientation; masturbation as a neutralizing ritual 3–5 times per day; the onset of depressive symptoms
8 months before treatment	Suicidal ideation episodes accompanied by commando auditory hallucinations; do not continue to act
6 months before treatment	Treatment for the first time; diagnosis of severe depression with psychotic symptoms and GOK; treatment is stopped on its own
Day 1 of treatment	Inpatient admission; CY-BOCS 34; GAF 31–40
Day 4 of treatment	CY-BOCS 17
Day 12 of treatment	Returning from treatment; GAF 61–70
1 month post-pandemic	Outpatient visits; CY-BOCS 26; good medication adherence; have not returned to school; compulsions are still ongoing

Table 2. CY-BOCS serial scores during treatment and at outpatient visits

Assessment time	Obsession (0–20)	Compulsions (0–20)	Total (0–40)	Interpretation
Day 1 of treatment (hospitalization)	19	15	34	Very heavy
Day 4 of treatment (hospitalization)	11	6	17	Medium
1 month post-return (outpatient)	14	12	26	Weight

METHOD

This study employed a descriptive clinical case report design to examine the clinical presentation, diagnostic formulation, management, and short-term course of an adolescent with obsessive-compulsive disorder (OCD) characterized by sexual orientation-related obsessions and repetitive masturbation as a neutralizing compulsion, accompanied by a severe depressive episode with psychotic symptoms. Clinical data were collected during psychiatric hospitalization and outpatient follow-up through psychiatric interviews, mental status examinations, physical and neurological examinations, reviews of previous treatment history, and collateral information from the patient's family.

Diagnostic assessment focused on intrusive thoughts, compulsive behaviors, depressive and psychotic symptoms, symptom severity, functional impairment, psychosocial factors, and differential diagnoses. Particular attention was given to the functional relationship between sexual orientation-related obsessions and repetitive masturbation to distinguish OCD-related compulsions from compulsive sexual behavior disorder. Diagnoses were established using the

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) and Pedoman Penggolongan dan Diagnosis Gangguan Jiwa di Indonesia III (PPDGJ-III). The patient was diagnosed with OCD with good insight and a severe depressive episode with psychotic symptoms.

Obsessive-compulsive symptom severity was assessed using the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), with particular attention to sexual orientation-related obsessions and masturbation as a neutralizing compulsion. Assessments were conducted at three time points: hospital admission, the fourth day of hospitalization, and the outpatient follow-up visit one month after discharge. The corresponding CY-BOCS total scores were 34, 17, and 26, respectively. Global functioning was assessed using the Global Assessment of Functioning (GAF) scale, with scores improving from the 31–40 range at admission to the 61–70 range at discharge.

Management included pharmacological and nonpharmacological interventions. Pharmacotherapy consisted of sertraline 50 mg once daily in the morning and aripiprazole 2.5 mg twice daily, with plans for gradual sertraline dose titration during outpatient follow-up. Nonpharmacological interventions included psychoeducation for the patient and family regarding intrusive thoughts, the obsessive-compulsive cycle, medication adherence, and prognosis. Family members were advised to reduce repeated reassurance, which could reinforce compulsive behaviors. Supportive psychotherapy and cognitive behavioral therapy incorporating exposure and response prevention (ERP) were provided to address masturbation as a neutralizing compulsion, repeated checking of bodily responses, and reassurance-seeking behaviors. Behavioral activation and stimulus management were also implemented through structured daily activities and restrictions on electronic device use and access to sexually explicit content.

RESULT AND DISCUSSION

This case illustrates SO-OCD in adolescents with a form of compulsive that is rarely reported, namely masturbation as a neutralizing ritual. The clinical value does not lie in the rarity of the disorder, but in the high risk of misinterpretation of behavior that appears on the surface.

Distinguishes compulsions from compulsive sexual behaviors. The main differentiator is not the frequency of the behavior, but its function. Compulsive sexual behavior disorders in ICD-11 are characterized by repeated failures to control intense sexual urges, with behaviors that persist despite adverse consequences. In these cases, the behavior is triggered by egodystonic intrusive thoughts, performed to relieve anxiety, provide temporary relief, and be followed by guilt. The patient explicitly states that masturbation is not performed to obtain sexual satisfaction. This pattern of triggers, rituals, temporary relief, and recurrent anxiety is the structure of GOK compulsions. A summary of the differentiators is presented in Table 3. The management consequences are fundamentally different: GOK compulsions require ERP and selective serotonin reuptake inhibitors, rather than approaches that focus on controlling sexual drive.

The role of religiosity and iatrogenic risk. The patient's religious background reinforces the egodystonicity of the obsession while directing its causal attribution: the patient believes his depression is caused by masturbation, not the other way around. This kind of moral

framework has been shown to be associated with increased suffering and the perception of addiction that is not always proportional to the actual degree of behavioral dysregulation. In a highly religious Muslim sample, the degree of religiosity is specifically related to obsessive symptoms and is mediated by beliefs about the importance of mind control as well as by guilt. The clinical implications are important. When clinicians adopt the patient's moral framework and position masturbation as a matter of self-discipline or value violation, the intervention has the potential to reinforce guilt and prolong the cycle of obsession-compulsions instead of alleviating them. The same applies to repeated calming from the family, which, although given with the intention of helping, actually functions as a compulsive booster.

Psychodynamic formulations. The following description is hypothetical and is intended to explain the selection of obsessive themes and the factors that sustain them, not to explain the causes of the disorder. It should be emphasized that we do not interpret the patient's obsession as an expression of repressed same-sex attraction. Such an interpretation is not supported by empirical evidence, is contrary to the egodystonic nature of obsessive-compulsive SO-OCD, and clinically risks reinforcing the patient's belief that his or her doubts need to be answered thereby aggravating the symptoms.

The patient lost his father at the age of nine and thereafter experienced repeated changes in father figures along with his mother's four marriages. In early adolescence, the stepfather who was present did not live at home and had hearing impairment, so the interaction between the two almost did not occur. The consolidation of identity in adolescence thus took place without a stable male identification figure and without an adult who could be a place to validate his internal experience. Prolonged loneliness at home, which the patient himself attributes to his behavior, while providing time, privacy, and access to gadgets that are a means of carrying out compulsions.

In this context, obsessive doubt leads to the realm that most demands certainty for the patient, namely the moral-religious identity and the sexual identity that is being formed. Masturbation can be understood as a form of undoing, that is, an attempt to cancel a perceived threatening thought through actions that seem to prove otherwise. Because the act at the same time violates the values it adheres to, the resulting relief is immediately replaced by guilt, and the cycle repeats with intensified intensity. This formulation is complementary to the explanation-cognitive behavior of negative reinforcement, not a replacement for it. That at the one-month visit after discharge, the patient has not returned to school and spends most of his time alone at home shows that the environmental factors that maintain the cycle have not been addressed, even though pharmacotherapy adherence is good. Interventions at the environmental level and social engagement therefore need to go hand in hand with pharmacotherapy and ERP, rather than waiting for symptoms to subside first.

Obsession versus delusions. Even if the patient experiences one episode of commanding auditory hallucinations, his intrusive thoughts are still recognized as coming from himself, actively resisted, and accompanied by good judgment. All three are characteristics of obsessions, not delusions. Hallucinations occur at the peak of depressive episodes and are mood-compatible, so they are more accurately understood as psychotic symptoms of severe depression than signs of schizophrenic spectrum disorder. This distinction determines the choice of therapy and prognosis (Rudrabhatla et al., 2024; Steele et al., 2025) .

Diagnostic hierarchy issues. PPDGJ-III directs that the diagnosis of GOK be established only when there is no depressive disorder at the time of the onset of obsessive-compulsive symptoms, and if both are not prominent, depression is prioritized as the primary diagnosis. In this case, both syndromes appear in close proximity and both cause significant stress, so the application of the hierarchical rule is not simple. The DSM-5-TR does not impose a similar hierarchy and allows for the simultaneous enforcement of both diagnoses. We chose to include both because each requires specific interventions that cannot be replaced by the treatment of one alone (Allely & Pickard, 2024; Stiede et al., 2024).

Pharmacotherapy considerations. GOK generally requires selective serotonin reuptake inhibitors with higher doses and longer duration than depressive disorders (Geller et al., 2012). Meta-analyses in adults showed that higher doses were associated with better efficacy, a pattern that differs from major depressive disorders, although accompanied by increased withdrawal rates due to side effects (Bloch et al., 2006). Randomized controlled trials in children and adolescents showed that the combination of sertraline and cognitive behavioral therapy yielded better results than either (Team, 2004). In patients with partial response, the addition of cognitive behavioral therapy was shown to be superior to antipsychotic augmentation, so ERP remained a priority and not a complement (Simpson et al., 2013). In this case, the patient was still at the initiation dose upon discharge, which is below the therapeutic range for GOK. The strategy of starting from low doses is justified in patients with a history of discontinuation triggered by concerns about side effects, as building trust in treatment is a prerequisite for long-term therapy success. However, the consequence is that the improvement observed during treatment cannot be attributed to pharmacological effects on obsessive-compulsive symptoms, and continued titration in outpatient services is the primary determinant of outcomes. This is reflected in the one-month postdischarge visit, when patients report good adherence to medication while obsessive-compulsive symptoms are still at severe. The combination of good adherence with doses that are still at the initiation level suggests that the picture is more accurately understood as an inadequate dose than as a failure of response to SSRIs. The clinical implication is that the most reasonable next step is to continue titration towards the therapeutic range, rather than to change medication or add augmentation.

Interpretation of serial CY-BOCS scores. The score pattern in this case provided information that went beyond the magnitude of the improvement. The sharp decline from 34 to 17 in a span of several days was less consistent with the course of the GOK therapy response, which generally takes weeks, especially since the patient was still at the initiation dose. What is notable is that the lowest scores were recorded when the patient was in the environment that most restricted the opportunity to perform the compulsions, i.e. an inpatient ward without privacy and without access to gadgets, while the score increased again to 26 on the outpatient assessment after the patient returned to the home environment that restored both. The subscale pattern supports this interpretation: the decrease in the compulsive subscale during hospitalization was much sharper than that of the obsession subscale, which suggests that what changed mainly was the opportunity to perform the ritual, not the intensity of the drive. These findings have practical implications. In GOK with compulsions that require privacy to be performed, the assessment of severity during hospitalization risks resulting in a lower estimate than the actual condition, so decisions about discharge readiness and dose adequacy should not

be based on hospitalization scores alone. Reassessment of the patient's home environment is necessary to obtain a valid picture.

Limitations. As a single case observation without a comparison group, this report cannot conclude the effectiveness of therapy. Post-discharge assessments are only conducted at one point in time, i.e. one month after the patient discharges, so the course of medium-term symptoms and the final outcome of sertraline titration cannot be assessed. Most of the information is sourced from the patient's own reports, and the CY-BOCS assessment is conducted by a single examiner without an inter-rater reliability test. The proposed psychodynamic formulation was compiled from clinical interviews without a structured psychodynamic assessment, so it needs to be read as a working hypothesis. This report is therefore intended as a contribution to the understanding of phenomenology and diagnostic differentiation, not as evidence regarding therapeutic outputs.

Table 3. Differentiators of compulsions in GOK and compulsive sexual behavior disorders

Aspects	Compulsions in GOK	Compulsive sexual behavior disorder
Triggers	Egodystonic intrusive thoughts	Sexual urges or desires
Behavioral function	Neutralize anxiety	Gaining sexual satisfaction
Experience while doing	Unpleasant; accompanied by tension	Fun, at least at first
After the behavior	Temporary relief followed by guilt	Satisfaction; regret can follow
When prevented	Anxiety rises sharply	Increased motivation; anxiety is not always
Overview	Generally good	Varies
First-line therapy	ERP with SSRI therapeutic dose for GOK	Behavioural motivation and addiction-based regulation interventions

CONCLUSION

This case report illustrated how sexual orientation-related obsessions in an adolescent with obsessive-compulsive disorder (OCD) manifested as repetitive masturbation performed as a neutralizing compulsion to alleviate anxiety and obtain reassurance. The functional relationship between intrusive thoughts and ritualized behaviors was central to the diagnostic formulation, alongside the assessment of a comorbid severe depressive episode with psychotic symptoms and a history of suicidal ideation. Following combined pharmacological and psychological interventions, the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) score decreased from 34 at admission to 17 during hospitalization but subsequently increased to 26 at the one-month postdischarge follow-up. At that time, compulsive behaviors persisted, and the patient had not resumed school attendance. These findings indicated incomplete clinical recovery and highlighted the importance of considering environmental factors and functional outcomes when interpreting changes in symptom severity. However, the single-case design and limited follow-up period precluded definitive conclusions regarding treatment effectiveness or the underlying causes of symptom fluctuations.

Future research should include larger adolescent samples and longer follow-up periods to improve understanding of the clinical presentation, diagnostic challenges, and longitudinal course of sexual orientation-related obsessions accompanied by sexual behaviors functioning

as neutralizing compulsions. Repeated assessments across inpatient and community settings should evaluate obsessive-compulsive symptoms, depressive and psychotic manifestations, suicide risk, school attendance, and psychosocial functioning. Prospective studies should also investigate the potential associations of pharmacological treatment, engagement in exposure and response prevention (ERP), family accommodation, loneliness, and moral incongruence with sustained clinical improvement. Culturally sensitive research is needed to identify therapeutic approaches that respect patients' religious and personal values while minimizing stigma and avoiding the reinforcement of compulsive reassurance-seeking behaviors. The use of standardized diagnostic interviews, independent clinical assessors, and systematic documentation of treatment delivery would further strengthen the reliability, validity, and interpretability of future findings.

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