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CASE REPORT

Obsessive compulsive disorder with gender identity related obsessions: a diagnostic challenge in an adolescent

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Abstract

Background: Obsessive compulsive disorder (OCD) can present with a wide range of symptom dimensions, including less commonly recognized taboo obsessions related to sexual orientation and gender identity. These presentations may lead to diagnostic confusion, particularly with gender dysphoria, especially in adolescents.

Case description: We report the case of a 17-year-old male who presented with a 4-year history of intrusive, distressing doubts about being transgender. The thoughts were ego dystonic, repetitive, and associated with significant anxiety and functional impairment. The patient engaged in multiple compulsive behaviors, including mirror checking, genital checking, mental review of past behaviors, and repeated reassurance seeking. Mental status examination revealed preserved insight and absence of psychotic features. Careful clinical evaluation helped differentiate OCD-related gender identity obsessions from gender dysphoria.

Management and outcome: The patient was treated with fluoxetine, titrated up to 60 mg/day, along with cognitive behavioral therapy (CBT) incorporating exposure and response prevention. Over 12 weeks, there was a significant reduction in symptom severity, with improvement in functioning and a decrease in Yale Brown Obsessive Compulsive Scale (YBOCS) score from 22 to 14.

Conclusion: This case highlights the importance of recognizing gender identity-related obsessions as a subtype of OCD and differentiating them from gender dysphoria. Early identification and appropriate treatment can lead to favorable outcomes and prevent unnecessary interventions.

Keywords: obsessive compulsive disorder, gender identity obsessions, gender dysphoria, adolescents, exposure and response prevention, fluoxetine

Introduction

Obsessive compulsive disorder (OCD) is a chronic psychiatric condition characterized by intrusive, unwanted thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) performed to reduce distress (1). Epidemiological studies suggest that OCD affects approximately 1–3% of the population worldwide (2).

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The disorder commonly shows a bimodal onset pattern, with peaks in late childhood and early adulthood (2). Among the different symptom dimensions, sexual and gender identity-related obsessions are less frequently reported, particularly in sociocultural settings such as India, where stigma surrounding sexuality and gender remains significant (3). These symptoms fall within the domain of taboo obsessions and typically present as intrusive doubts about one's gender identity or fears of becoming transgender (4). Such thoughts are ego dystonic, experienced as inconsistent with the individual's sense of self, and are associated with marked distress (5). This presentation contrasts with gender dysphoria, where the experience of gender incongruence is persistent, ego syntonic, and often accompanied by a desire for transition (1). Distinguishing between these two conditions is clinically important, as misinterpretation may result in inappropriate management or delay in appropriate psychiatric care (6). Adolescents may be particularly vulnerable to such diagnostic confusion due to ongoing identity development and sociocultural pressures (7). Recent literature highlights the importance of detailed phenomenological assessment, including careful evaluation of insight and identification of both overt and covert compulsions such as reassurance seeking and mental rituals (8). This report aims to describe the clinical presentation and management challenges in an adolescent with gender identity-related obsessions.

Case report

A 17-year-old male, studying in the 12th standard, with no prior psychiatric illness, presented with a 4-year history of intrusive doubts about being transgender. There was no identifiable predisposing or precipitating psychosocial stressors prior to the onset of symptoms. There was no history suggestive of trauma, bullying, substance use, medical illness, or developmental difficulties. Family history was negative for OCD, anxiety disorders, mood disorders, psychosis, gender dysphoria, or other major psychiatric illness.

These intrusive doubts about being transgender were frequent, distressing, and difficult to control, leading to significant impairment in daily functioning. The patient was aware that these thoughts were irrational but found them difficult to resist. To manage the anxiety, he engaged in repeated mirror checking for feminine features, genital checking, mental review of past behaviors, repeated examination of childhood photographs, and frequent reassurance seeking from family members. He expressed persistent fear that others might perceive him as transgender, along with concerns about ridicule and bringing shame to his family. Over time, these symptoms worsened, affecting his academic performance and social interactions. On mental status examination, he appeared anxious, with a congruent affect. Thought form was coherent and goal-directed. Intrusive doubts about gender identity were present, without any delusional beliefs. Insight was preserved, and judgment and cognition were intact. The main diagnostic consideration was between OCD with gender identity-related obsessions and gender dysphoria. The ego-dystonic nature of the thoughts, associated distress, resistance, and presence of compulsive behaviors supported a diagnosis of OCD. There was no evidence of a sustained desire for gender transition or discomfort with sexual characteristics. Body dysmorphic disorder and delusional disorder were considered less likely. No evidence of other psychiatric or neurological comorbidity was identified in clinical assessment. Routine laboratory investigations, including complete blood count, renal and liver function tests, thyroid profile, serum electrolytes, and fasting blood glucose, were within normal limits. Neuroimaging was not performed, as there were no neurological signs, cognitive deficits, or other clinical features suggestive of an organic etiology.

The patient was diagnosed with OCD with sexual and gender identity-related obsessions. His baseline Yale Brown Obsessive Compulsive Scale (YBOCS) score was 22. He was started on fluoxetine, gradually titrated from 20 mg/day to 60 mg/day. Cognitive behavioral therapy (CBT) with exposure and response prevention was also initiated. At the 12-week follow-up, there was a clear reduction in symptom severity, with the YBOCS score decreasing to 14 and improvement in overall functioning.

Discussion

This case highlights an uncommon but clinically relevant presentation of OCD involving gender identity-related obsessions. The key challenge lies in distinguishing these intrusive thoughts from genuine gender dysphoria (9). In OCD, such thoughts are experienced as unwanted, distressing, and inconsistent with the individual's identity, often accompanied by compulsive attempts to reduce anxiety (5). In contrast, gender dysphoria is characterized by a stable and ego-syntonic identification with another gender, usually accompanied by a desire for transition (1). In this patient, several features pointed towards OCD. The thoughts were distressing and inconsistent with his self-concept (4). Repetitive checking, reassurance seeking, and mental reviewing were prominent, indicating compulsive behavior (8). Preserved insight further supported a non-psychotic diagnosis (5). Adolescence is a period of active identity formation, which can make it difficult to distinguish between normal developmental exploration

and pathological symptoms (3). Cultural attitudes toward gender and sexuality may further contribute to distress and delay in seeking help (7). Gender identity-related obsessions are often underrecognized in clinical practice, partly due to stigma and discomfort in discussing such themes (9). Greater awareness of these presentations can help improve early identification and management (4). Treatment involves a combination of pharmacotherapy and psychotherapy. Selective serotonin reuptake inhibitors (SSRIs) and CBT with exposure and response prevention remain the mainstay of treatment (5). Advances in the neurobiological understanding of OCD subtypes continue to refine this diagnostic distinction (10). Psychoeducation is essential, particularly in addressing family involvement and reducing reassurance behaviors, which can maintain the disorder (8). Misdiagnosis may have important consequences, including inappropriate interventions or delays in appropriate care (6). Careful longitudinal assessment and attention to phenomenology are therefore crucial (11).

Conclusion

This case underscores the importance of considering OCD in adolescents presenting with intrusive doubts about gender identity. Differentiating such presentations from gender dysphoria is essential for appropriate management (6). Early treatment with SSRIs and CBT can lead to significant improvement (5). Greater awareness and culturally sensitive assessment are particularly important in the Indian setting (7).

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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