



DISSOCIATIVE TRAUMA AND OBSESSIVE-COMPULSIVE SYMPTOMS IN PRIMARY CARE: A CASE REPORT AND HOME-BASED INTERVENTIONS

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Abstract

Background

In Bali, 1,884 cases of mental disorders were recorded in 2024, underscoring increasing mental health demands in primary care. Comorbid dissociation and obsessive-compulsive disorder (OCD) can be difficult to detect and manage, particularly when trauma histories are present. This case report describes a trauma-informed biopsychosocial approach using feasible home-based adjuncts in a primary care setting.

Case Presentation

A 21-year-old female university student presented with poor concentration, intrusive negative inner voices, intrusive sexual urges, fixation on strangers, compulsive pornography use, and compulsive masturbation, accompanied by shame, social withdrawal, and sleep disturbance. She disclosed repeated childhood sexual abuse. Screening showed clinically significant dissociation (Dissociative Experiences Scale [DES] >30) and severe OCD (Yale-Brown Obsessive Compulsive Scale [Y-BOCS] 28). Psychotic disorder was considered unlikely due to preserved reality testing.

Management and Outcome

The patient received psychoeducation and a primary care psychiatry plan emphasizing trauma-informed, home-based strategies: mindfulness breathing, grounding techniques, and omega-3 supplementation with nutritional counseling. At week 1, she reported mild relief of intrusive voices during dissociative episodes when applying breathing and grounding exercises. By week 3, she reported fewer dissociative episodes, reduced severity of compulsive behaviors (including decreased compulsive masturbation frequency), and improved sleep quality and mood stability alongside more regular eating patterns.

Conclusion

This case highlights that early, trauma-informed assessment using standardized tools (DES and Y-BOCS) can support accurate recognition of dissociative-OCD presentations in primary care. A biopsychosocial approach integrating structured home-based interventions (mindfulness, grounding, and nutrition/omega-3 support) may provide practical symptom relief and functional improvement while pathways to specialist care are arranged.

Keywords: biopsychosocial approach, childhood trauma, dissociation, obsessive-compulsive disorder, primary care psychiatry.

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INTRODUCTION

Obsessive-compulsive disorder (OCD) is a long-term psychiatric condition characterized by intrusive thoughts and repetitive behaviors that disrupt daily functioning. OCD affects about 2–3% of the global population, with onset most often occurring during adolescence or early adulthood (Sideli et al., 2023). Dissociative disorders, such as depersonalization, derealization, and dissociative identity disorder, occur in 1–2% of the population and are strongly linked to childhood trauma, particularly sexual abuse and neglect (Soffer-Dudek, 2023). The intersection between OCD and dissociation has drawn increasing attention, as trauma-related dissociation can intensify compulsive symptoms, while compulsive rituals may perpetuate dissociative states, creating a self-sustaining cycle of symptoms (Li et al., 2025; Su et al., 2023).

In Indonesia, psychiatric morbidity continues to rise, with national surveys showing higher rates of anxiety, depression, and OCD among adolescents and young adults (Cristea et al., 2025). The Indonesian National Adolescent Mental Health Survey (I-NAMHS) found that nearly one in five adolescents has experienced clinically significant psychiatric symptoms, with OCD and trauma-related disorders among the most common (Fajriana et al., 2025). In Bali, 1,884 cases of mental disorders were recorded in 2024, reflecting the growing number of mental health disorders in primary care (Badan Pusat Statistik Provinsi Bali, 2025; Dinas Kesehatan Provinsi Bali, 2024). Local studies further show that trauma-related symptoms are prevalent among adolescents exposed to sexual abuse, domestic violence, and psychosocial stressors, with dissociation and OCD often co-occurring (Universitas Udayana, 2023; RSJ Bangli, 2022).

The coexistence of dissociation and OCD presents significant challenges in clinical practice. Dissociation can obscure compulsive rituals, making OCD harder to identify, while OCD can reinforce dissociative states, thereby complicating diagnosis and delaying the patient from receiving treatment (Sideli et al., 2023). This overlap worsens prognosis, increases functional impairment, and raises the risk of chronic illness. Primary care physicians often lack structured pathways for trauma-related OCD, and home-based strategies such as mindfulness, grounding techniques, and nutritional education remain underutilized despite growing evidence of their benefits (Reis et al., 2024; Sheikh, 2025). In Indonesia, systemic barriers, such as limited psychiatric specialists, uneven service distribution, and persistent stigma, further restrict the integration of trauma-informed care into primary care (Cristea et al., 2025; Dinas Kesehatan Provinsi Bali, 2024).

Globally, mindfulness-based interventions have shown effectiveness in reducing OCD severity and improving emotional regulation. Mindfulness has been found to influence the cortico-striato-thalamo-cortical circuit, enhance prefrontal control of the amygdala, and reduce reliance on compulsive rituals (Reis et al., 2024; Zhang et al., 2021). In trauma-related dissociation, mindfulness promotes grounding and self-awareness, alleviating depersonalization and derealization (Soffer-Dudek, 2023). Nutritional interventions also play an important role, as diets rich in omega-3 fatty acids and whole foods improve synaptic plasticity, reduce neuroinflammation, and stabilize neurotransmitter systems involved in OCD and trauma-related disorders (Nguyen et al., 2021; Dawson et al., 2025). Despite this evidence, mindfulness and nutritional education remain insufficiently integrated into Indonesian primary care, highlighting the need for culturally adapted approaches (Universitas Gadjah Mada, 2021).

By documenting the patient's clinical presentation, diagnostic process, and response to early interventions, this study emphasizes the importance of trauma-informed care in primary care settings. It also highlights the potential of incorporating mindfulness, grounding techniques, and nutritional education into routine practice, while stressing the need for culturally adapted interventions in Indonesia, where systemic barriers and stigma continue to limit access to specialized psychiatric care (RSJ Bangli, 2022; Universitas Udayana, 2023). The aim of this case report is to present a dissociative-OCD case in a university student managed in primary care and to describe the response to biopsychosocial and home-based interventions.

METHOD

This study is a descriptive case report conducted in a primary care setting in Indonesia. Clinical assessment was based on a biopsychosocial and trauma-informed approach, including detailed history taking, mental status examination, and the use of standardized screening instruments. Dissociative symptoms were assessed using the Dissociative Experiences Scale (DES), while obsessive-compulsive symptom severity was evaluated using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). Management consisted of mindfulness practices, grounding techniques, nutritional counselling, and omega-3 supplementation. Written informed consent was obtained from the patient for publication of this case report. Patient anonymity was strictly maintained, and no identifiable personal information is included.

CASE REPORT

A 21-year-old female university student visited a primary care clinic with complaints of poor concentration during lectures. She reported frequently hearing intrusive voices in her mind, often with negative and disturbing content. These voices included sudden urges to engage in sexual activity with individuals she encountered, such as strangers, religious figures, or even deceased persons. She also described her compulsive need to view adult films, which reinforced her intrusive thoughts further.

The patient explained that in daily life, she often fixated intensely on one person, stopping her activities to stare at them while experiencing intrusive sexual thoughts. These thoughts appeared suddenly without clear triggers. To relieve the tension, she engaged in compulsive masturbation using her fingers or objects such as pencils. She expressed distress about these behaviors, describing feelings of shame, low self-confidence, and difficulty sharing her problems with family or peers.

The patient reported that she has no family history of psychiatric illness. The patient also denied any previous psychiatric diagnoses or treatments. However, she disclosed a background of childhood trauma, including experiences of sexual abuse, which may have contributed to her current symptoms.

On examination, the patient appeared withdrawn, often staring blankly or looking downward, with poor focus during conversation. Her vital signs were within normal limits: blood pressure 120/80 mmHg, temperature 36.8°C, respiratory rate 20 breaths/min, and pulse rate 86 beats/min. The general physical examination from head to toe was unremarkable.

The combination of intrusive voices, compulsive sexual urges, repetitive behaviors to reduce anxiety, and emotional detachment strongly suggests obsessive-compulsive disorder with dissociative features. The history of childhood trauma provides a significant etiological factor, supporting the diagnosis of trauma-related dissociation coexisting with OCD.

Next, standardized psychiatric scales were employed to establish the diagnosis. The Dissociative Experiences Scale (DES) was administered, yielding a score greater than 30, which is consistent with clinically significant dissociation (Li et al., 2025). The DES is widely used to quantify dissociative symptoms such as depersonalization, derealization, and identity fragmentation, and scores above 30 are strongly associated with trauma-related dissociative disorders (Sideli et al., 2023). The patient's high DES score confirmed the presence of dissociative phenomena, particularly intrusive voices and episodes of detachment from reality.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) was also administered, with the patient scoring 28, which corresponds to severe obsessive-compulsive disorder (Reis et al., 2024). The Y-BOCS is the gold standard for assessing OCD severity, measuring both the frequency and intensity of obsessions and compulsions. A score above 24 indicates severe OCD, and this patient's score confirmed the presence of clinically significant compulsive symptoms, particularly intrusive sexual urges and compulsive masturbation (Sheikh, 2025). The combined use of DES and Y-BOCS provided a comprehensive assessment of the patient's dissociative and compulsive symptoms, allowing for a more accurate diagnosis.

Differential diagnoses were carefully considered to ensure diagnostic accuracy. Psychotic disorders were excluded because the patient retained reality testing, and her intrusive voices were consistent with dissociative phenomena rather than hallucinations (Soffer-Dudek, 2023). Post-traumatic stress disorder (PTSD) without OCD was excluded because the patient exhibited compulsive rituals in addition to trauma-related symptoms, indicating a comorbid presentation rather than isolated PTSD (Su et al., 2023). Personality disorders were considered but excluded because the dissociative episodes and compulsions were episodic and trauma-related rather than pervasive across all interpersonal contexts (Sideli et al., 2023). The differential diagnosis process underscored the importance of using standardized scales and trauma-informed assessment in primary care settings.

Following the diagnostic evaluation, the patient was introduced to mindfulness and grounding techniques and advised to take fish oil supplements. She was instructed to return to primary care within a week and continue for 3 weeks. If the symptoms persisted, we would consider referring her to a psychiatrist.

The patient's background revealed significant risk factors for dissociation and OCD. She had a history of childhood sexual trauma, which is strongly associated with both conditions (Li et al., 2025). She also reported social withdrawal and academic difficulties, which are common functional impairments in comorbid dissociation and OCD (Fajriana et al., 2025). Her nutritional status was suboptimal, with irregular eating patterns and poor dietary quality, which may have contributed to emotional dysregulation and exacerbated compulsive symptoms (Nguyen et al., 2021; Dawson et al., 2025).

The case was documented in detail to highlight the clinical overlap between dissociation and OCD, the importance of standardized diagnostic scales, and the need for trauma-informed differential diagnosis in primary care settings (Cristea et al., 2025; Universitas Gadjah

Mada, 2021). The documentation emphasized the patient's risk factors, symptom profile, and response to early interventions, providing a comprehensive account of the clinical course.

FOLLOW-UP

The patient was initially treated in a primary care clinic using a biopsychosocial approach that emphasized home remedies and trauma-informed strategies. The clinical course was documented at weeks one and three to capture the trajectory of her response to early interventions.

Week 1: The patient was introduced to mindfulness-based breathing exercises and grounding techniques. She practiced these exercises daily, focusing on slow diaphragmatic breathing and sensory grounding using tactile objects. During the first week, she reported mild relief from intrusive voices, particularly when engaging in breathing exercises during episodes of dissociation. This immediate effect is consistent with evidence that mindfulness enhances present-moment awareness and reduces depersonalization symptoms (Soffer-Dudek, 2023; Sideli et al., 2023).

Week 3: The patient received nutritional counseling focused on balanced dietary intake and omega-3 supplementation. The patient's eating patterns improved, with more regular meals and increased consumption of fruits, vegetables, and protein. She reported better sleep quality and mood stability after three weeks, consistent with studies demonstrating that dietary quality and nutrient intake are associated with emotional regulation and reduced OCD symptom severity (Nguyen et al., 2021; Dawson et al., 2025).

Table 1. Follow Up

| Domain | Baseline | Week 1 | Week 3 |
|-----------------------|--|--------------------|---------------------------------------|
| Dissociative symptoms | Frequent dissociation ; intrusive voices | Reduced frequency | Occasional, less intense dissociation |
| OCD symptoms | Moderate-severe compulsive behaviours | Mild reduction | Further reduction |
| Sleep quality | Poor, fragmented | Slight improvement | Improved sleep continuity |
| Mood | Anxious, emotionally labile | More stable | Improved mood stability |

Overall, the patient demonstrated positive clinical progress in the early stages of treatment. Her dissociative symptoms became less frequent, her compulsive behaviors decreased in severity, and her emotional regulation improved. These outcomes highlight the feasibility and effectiveness of integrating home remedies into

primary care psychiatry, particularly in resource-limited settings such as Indonesia (Dinas Kesehatan Provinsi Bali, 2024; RSJ Bangli, 2022).

DISCUSSION

Trauma-dissociation-OCD Relationship and Diagnostic Challenges in Primary Care

Previous studies support this dual pathway. Childhood trauma has been strongly associated with both obsessive-compulsive symptoms and dissociative experiences, while compulsions may develop as attempts to regulate intrusive distress (Kılıç et al., 2025). Dissociative features such as depersonalization and derealization frequently co-occur with OCD, creating a self-perpetuating cycle in which trauma-related dissociation worsens compulsive behaviors, and compulsions in turn reinforce dissociative states (Soffer-Dudek, 2023).

Furthermore, the patient's intrusive voices, compulsive sexual urges, and social withdrawal highlight the clinical challenge of differentiating trauma-related dissociation from primary psychotic disorders and recognizing compulsive rituals as maladaptive coping mechanisms (Sideli et al., 2023; Soffer-Dudek, 2023). The overlap between dissociation and OCD is increasingly recognized as a distinct clinical entity, with trauma-related dissociation exacerbating compulsive symptoms and compulsive rituals reinforcing dissociative states, creating a vicious cycle of symptom maintenance (Li et al., 2025; Su et al., 2023).

Role of Mindfulness and Grounding on Dissociative and OCD Symptoms

Mindfulness interventions can reduce obsessive-compulsive symptoms by increasing metacognitive awareness and reducing automatic engagement in compulsive rituals. Neuroimaging studies show that mindfulness modulates activity in the cortico-striato-thalamo-cortical (CSTC) circuit, which is hyperactive in OCD, leading to fewer intrusive thoughts and compulsive rituals (Reis et al., 2024; Sheikh, 2025). Mindfulness also improves prefrontal regulation of the amygdala, reducing hyperarousal and enhancing emotional regulation, which is particularly relevant in trauma-related dissociation (Zhang et al., 2021). In this case, mindfulness and grounding techniques provided immediate relief during dissociative episodes by restoring the patient's awareness of the present moment. Dissociation commonly involves feelings of detachment, intrusive inner experiences, or emotional disengagement. Through slow diaphragmatic breathing and tactile grounding, the patient was able to reconnect with her body and surroundings, helping to interrupt intrusive thoughts and emotional withdrawal (Soffer-Dudek, 2023).

During the first week of intervention, she noted a slight improvement in intrusive voices

while practicing mindfulness. This finding aligns with evidence that mindfulness enhances present-moment focus and reduces dissociative symptoms (Soffer-Dudek, 2023; Sideli et al., 2023). By the third week, her progress became more pronounced: her dissociative episodes diminished, compulsive behaviors lessened, and emotional regulation improved. This clinical trajectory reflects findings that mindfulness strengthens attentional control and prefrontal modulation of the amygdala, thereby decreasing reliance on maladaptive coping rituals (Reis et al., 2024; Sheikh, 2025).

Contribution of Nutrition

Additionally, nutritional interventions play a critical role in psychiatric symptom regulation. Diets rich in omega-3 fatty acids and whole foods improve synaptic plasticity, reduce neuroinflammation, and stabilize neurotransmitter systems such as serotonin and dopamine, which are implicated in both OCD and trauma-related disorders (Nguyen et al., 2021; Dawson et al., 2025). Poor dietary quality has been associated with increased severity of OCD symptoms and emotional dysregulation, while ketogenic-informed diets have shown promise in reducing compulsive behaviors by modulating glutamatergic transmission (Lounici et al., 2024). In this case, nutritional counseling improved the patient's sleep and mood stability, supporting the role of dietary interventions in primary care psychiatry.

Implications for Primary Care Practice in Indonesia

The overlap between dissociation and OCD complicates diagnosis, as dissociative voices may mimic psychotic hallucinations, and compulsive behaviors may be misinterpreted as personality traits. Therefore, the use of standardized diagnostic scales such as the DES and Y-BOCS is essential in primary care to differentiate these conditions and guide health care professionals in providing appropriate treatment (Reis et al., 2024). Trauma-related dissociation exacerbates compulsive symptoms, while compulsive rituals reinforce dissociative states, creating a cycle that worsens prognosis and increases functional impairment (Sideli et al., 2023; Li et al., 2025). This overlap underscores the importance of trauma-informed care in primary care settings.

Limitations

However, although mindfulness, grounding techniques, and nutritional education are effective adjuncts, they still have limitations. Their effectiveness varies across individuals, requiring consistent practice and motivation, which may be difficult for patients with severe trauma-related symptoms (Sheikh, 2025). Home remedies cannot replace pharmacological or intensive

psychotherapeutic interventions in severe cases, and their evidence base in Indonesian populations remains limited (Universitas Gadjah Mada, 2021). Additionally, cultural stigma surrounding psychiatric symptoms may hinder adherence to mindfulness and nutritional interventions, underscoring the need for culturally adapted approaches (Cristea et al., 2025).

Mental health care in Indonesia faces systemic challenges, including limited psychiatric specialists, uneven distribution of services, and persistent stigma (Dinas Kesehatan Provinsi Bali, 2024; RSJ Bangli, 2022). Local studies emphasize the importance of integrating trauma-informed care into primary care pathways and leveraging community-based interventions, such as mindfulness programs in schools and universities (Universitas Udayana, 2023). This case demonstrates that even simple interventions such as breathing exercises and nutritional counseling can yield positive outcomes when implemented early in primary care. However, systemic barriers must be addressed to ensure the sustainability and scalability of such interventions.

Primary care physicians play a crucial role in the early detection and trauma-informed management of dissociative-OCD cases. By integrating standardized screening tools, culturally adapting mindfulness practices, and nutritional education, primary care can serve as the first line of defense against the progression of trauma-related psychiatric comorbidities (Fajriana et al., 2025; Universitas Udayana, 2023). This case demonstrates the feasibility of implementing simple, low-cost interventions in a resource-limited primary care setting and highlights several novel aspects. These include the use of standardized screening tools such as DES and Y-BOCS by a primary care provider, the application of feasible home-based interventions for trauma-related OCD with sexual content, and the integration of a trauma-informed biopsychosocial approach within an Indonesian primary care context. Together, these elements illustrate how primary care can bridge the gap between specialized psychiatric services and community-based mental health management.

This case report has several limitations. The findings are based on a single patient, which limits generalizability. The follow-up period was short, preventing assessment of sustained treatment effects and long-term outcomes. Standardised symptom measures, including DES and Y-BOCS, were not repeated at follow-up, limiting objective evaluation of symptom change over time. Finally, no formal psychiatric consultation was conducted during the observation period, and long-term outcomes following referral to specialised care were not available.

CONCLUSION

This case underscores the clinically important overlap between dissociation and OCD in a young adult with a history of childhood sexual trauma. Dissociative phenomena, intrusive inner experiences, and compulsive behaviours may obscure diagnosis and delay care. Routine use of brief screening tools (e.g., DES and Y-BOCS) helped to manage in this case.

For primary care practice, three practical steps are recommended: routinely screen for trauma history in young patients presenting with OCD symptoms; provide brief mindfulness/grounding training for primary care staff to deliver simple, safe skills at the first point of contact; and integrate basic nutrition counselling into mental health care as a supportive adjunct. Early trauma-informed interventions can reduce distress, improve emotional regulation, and strengthen functioning while referral pathways are arranged.

Future Research should prioritise prospective studies with larger samples in Indonesian primary care settings to evaluate the effectiveness and feasibility of mindfulness-based and nutritional interventions for OCD with comorbid dissociation, including outcomes on symptom severity, sleep quality, and functional recovery.

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