



Restraint Beneath the Surface: A Multidisciplinary Case Study of Comorbid OCD and SLD in an Adolescent

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Abstract: This case study examines the nuanced intersection of Obsessive-Compulsive Disorder (OCD) and Specific Learning Disorder (SLD) in an adolescent navigating academic, emotional, and social adversity in an urban Indian context. Through comprehensive psychological assessment and psychodynamic formulation, the report illustrates the cumulative impact of comorbidity on functioning and identity formation. The case underscores the importance of a multidisciplinary intervention Integrating cognitive-behavioural therapy, executive function remediation, individualized educational accommodations, and culturally attuned parental guidance. Emphasis is placed on early identification, cross-system collaboration, and caregiver involvement as pivotal to positive prognosis. This study contributes to the growing body of clinical literature addressing adolescent mental health in transitional socio-cultural environments.

Keywords: *Obsessive Compulsive Disorder, Specific Learning Disorder, Adolescent Mental Health, Urban India, Comorbidity, Clinical Psychology, Intervention Planning, Immigrant Family, Bullying.*

1. Introduction

Adolescence is a pivotal developmental stage marked by significant cognitive, emotional, and social transformations. In urban Indian settings, adolescents often navigate the

complexities of academic pressures, familial expectations, and sociocultural dynamics. When compounded by neuropsychiatric conditions such as obsessive-compulsive disorder (OCD) and Specific Learning Disorder (SLD), these challenges can significantly impede an adolescent's developmental trajectory.

Obsessive Compulsive Disorder (OCD) is a neuropsychiatric condition characterized by intrusive obsessions and repetitive compulsions, often emerging in childhood or adolescence. Specific Learning Disorder (SLD) is a neuro-developmental disorder involving persistent difficulties in academic skills (e.g., reading, writing, or math) that are unexpected given the child's intelligence and education level. Sahoo et al (2015). OCD is characterized by intrusive thoughts and repetitive behaviors, leading to considerable distress and functional impairment. SLD, on the other hand, involves persistent difficulties in reading, writing, or mathematical reasoning, despite adequate intelligence and educational opportunities. The co-occurrence of OCD and SLD can exacerbate the individual impact of each disorder, leading to compounded academic struggles, social isolation, and emotional distress.

Both OCD and SLD can significantly impair school functioning and psychosocial development, and when they cooccur the challenges are compounded. Bonti et al. (2024) Although each condition is distinct, clinicians have long noted that they frequently cooccur with other disorders for example, SLD often coexists with ADHD or anxiety, and pediatric OCD commonly presents alongside other internalizing or neurodevelopment disorders. Sharma et al. (2019) The comorbidity of OCD and SLD in adolescents is an important clinical concern because each disorder may exacerbate the other's impact, leading to complex presentations and special diagnostic and treatment considerations. Key issues discussed include prevalence and clinical presentation of this comorbidity, diagnostic challenges, cognitive profiles, developmental risk factors, and treatment outcomes in these specific cultural contexts.

Sahoo et al. (2015) note that when SLD cooccurs with other psychological problems, diagnosis becomes "difficult and tricky," as improvement in academics will require disentangling the learning issues from the emotional/behavioural symptoms. Clinicians must conduct a comprehensive assessment spanning cognitive testing, academic achievement, and mental health evaluation to parse out each contributing factor.

Some key diagnostic challenges include:

Overlapping symptoms and impairment: Both disorders can cause slow, effortful schoolwork and poor grades. A student with OCD might repeatedly check and correct assignments, appearing to have a writing disorder due to the extreme slowness. Conversely, a student with SLD might avoid homework, which could be mistaken for OCD avoidance if the

distress isn't clearly articulated. Only a detailed evaluation (including psycho-educational testing for SLD and psychiatric interview for OCD) can clarify the root causes of the academic underachievement.

Cognitive compensations masking symptoms: Bright adolescents with SLD often develop compensatory strategies that can hide their learning problems until work demands increase. If such a teen also has emerging OCD, they might attribute their difficulties entirely to anxiety or "perfectionism." It takes careful history taking to reveal longstanding learning issues underneath the new onset of OCD symptoms.

Denial or lack of awareness in family: In some cases, families might be more concerned about one issue and inadvertently ignore the other. For instance, parents of a child with dyslexia may normalize or overlook repetitive behaviors, dismissing them as quirks. Alternatively, in families where academic success is paramount (common in urban India), parents might focus on the child's study habits and dismiss early OCD rituals as "just stress" delaying diagnosis. Low awareness and stigma about both learning disabilities and mental illness can further impede recognition. Indian contexts in particular face challenges of limited awareness among teachers and families about SLD and comorbid psychological problems, leading to under-referral for proper evaluation.

Cultural and language factors: In children from immigrant or bilingual backgrounds, assessment is even more complex. Language barriers can make it hard to distinguish an SLD (such as a true reading disorder) from second language difficulties. Immigrant parents might misinterpret OCD symptoms due to cultural norms or may not have the vocabulary to describe subtle obsessions/compulsions to clinicians. (Schmengler *et al.* 2021) observed that children of immigrants often receive later diagnoses of neuro-developmental disorders because clinicians may misattribute symptoms to cultural or language issues, and parents may be less likely to report concerns early. A teen from an immigrant family struggling at school might initially be evaluated for an SLD when in fact they are also experiencing anxiety or OCD symptoms in response to acculturation stress or vice versa. Thus, culturally sensitive and bilingual assessment tools are essential to avoid misdiagnosis in this population.

To address these challenges, experts recommend a multidisciplinary approach to assessment. This includes collecting detailed developmental and family history, conducting standardized tests for learning disorders, and using screening questionnaires for anxiety/OCD when either domain of symptoms is hinted. Indian clinical guidelines specifically advise that when an adolescent with OCD shows academic decline or atypical features, an in-depth neuropsychological evaluation (covering intelligence, working memory, and specific learning

skills) should be done to detect any comorbid SLD. Likewise, any student diagnosed with SLD should be periodically screened for emerging emotional problems like OCD, given the high rates of internalizing symptoms in dyslexic youth. Only with such a comprehensive evaluation can clinicians differentiate what symptoms belong to OCD, SLD, or both (true comorbidity). Importantly, making the correct dual diagnosis allows for targeted interventions rather than attributing all difficulties to just one domain.

This case study delves into the clinical presentation, assessment, and intervention strategies for an urban Indian adolescent diagnosed with comorbid OCD and SLD. Emphasis is placed on culturally informed practices, the role of family dynamics, particularly maternal involvement, and the implementation of psycho educational and therapeutic interventions.

1.1 Treatment Outcomes and Management Considerations

Treating an adolescent who has both OCD and a specific learning disorder requires an integrated and sensitive approach. Each condition on its own can be debilitating, and together they may interact to make standard treatments less effective unless modifications are made. The encouraging news is that evidence-based treatments exist for both: Cognitive Behavioral Therapy (CBT) (especially Exposure and Response Prevention) and/or SSRIs are effective for pediatric OCD and specialized educational interventions (such as multisensory reading instruction for dyslexia) are effective for SLD. The challenge is how to combine or sequence these interventions and ensure one disorder is not impeding progress in treating the other (Peris et al. 2020)

Therapeutic challenges: The cognitive deficits in comorbid SLD can impact OCD treatment. As noted earlier, adolescents with learning disorders might struggle with aspects of CBT for example, a teen with dyslexia could have trouble keeping a written thought record, or one with an auditory processing disorder might not fully understand therapy instructions. OCD therapy often relies on the patient's ability to reflect on thoughts and use cognitive strategies; if those skills are underdeveloped due to a learning disability, the therapist must adapt. Indeed, the presence of comorbid SLD or ADHD in a youth with OCD is associated with more complicated treatment courses. Clinicians report needing to spend extra sessions building skills like memory strategies or using more visual aids to teach CBT concepts. Family involvement becomes even more critical parents and teachers may need to assist in skills reinforcement and accommodate the child's learning needs during treatment exercises.

Holistic and collaborative care is therefore emphasized. Sahoo (2015) stress that improvement in academics for SLD children with comorbid conditions demands a "comprehensive holistic treatment approach." This means simultaneously addressing the

learning problems (through academic support, tutoring, school accommodations) *and* the OCD (through therapy/medication), rather than tackling one and leaving the other for later. In an ideal scenario, a multidisciplinary team including a child psychiatrist or psychologist, a special education teacher or educational therapist, and the family works together. For instance, while a psychologist provides CBT for OCD, a learning specialist can work on study skills with knowledge of the OCD (e.g., understanding that a student's excessive rewriting is a compulsion and helping to set limits on it in the academic support context).

Medication management may also need tailoring. SSRIs, the common medications for pediatric OCD, generally do not negatively affect learning ability and can reduce anxiety enough to perhaps improve school functioning. However, if the adolescent also has ADHD (common in SLD cases), stimulants might be indicated, and the combination of SSRIs and stimulants requires careful monitoring by a clinician. There isn't evidence of a direct pharmacological approach for "OCD+SLD" specifically; rather, each condition is treated on its own merits, with attention to potential interactions (both pharmacological and psychological).

In terms of outcomes, research specifically on OCD–SLD comorbidity outcomes is lacking, but we can extrapolate from related findings on comorbid conditions. Generally, comorbidity tends to predict a more protracted or partial response to treatment in child psychiatry. A youth with multiple challenges might take longer to achieve remission of OCD symptoms and may show only incremental academic improvements over time. Family functioning also plays a role: if a family is coping with both the emotional burden of OCD *and* the school frustrations of SLD, they may experience higher stress, which can affect the consistency of implementing therapy techniques or homework.

One relevant study by Peris et al. (2020) examined outcomes of intensive OCD treatment in a diverse sample of youth and found that cultural/minority background can influence how well children respond to standard treatments. Specifically, they observed that nonwhite (largely immigrant or minority) children with OCD had better outcomes when given a tailored family focused therapy, whereas White children did similarly well in standard treatment. This implies that cultural and family context modifications can be crucial for optimizing results. By analogy, for an immigrant family dealing with OCD and SLD, treatments might need to incorporate cultural education, translation services, or family counselling to address differing beliefs about mental health and education. For example, immigrant parents might initially priorities academic success over mental health; a clinician needs to work with the family to show how treating OCD will help the teen in school, and how

addressing the learning issues will alleviate stress that could be fueling the OCD. When such personalized interventions are employed, outcomes improve noted that with culturally informed family therapy, minority youths' OCD symptoms reduced to a level of clinical remission on average, whereas those who received standard treatment had remaining moderate symptoms.

Additionally, school-based accommodations can greatly improve functional outcomes for these adolescents. Urban Indian schools, for instance, under Central Board of Secondary Education (CBSE) guidelines, now allow certain concessions for documented learning disabilities (such as extra time on exams, exemption from a second language, etc.). If a student has OCD that interferes with test taking (e.g., spending too long on compulsive checking), similar exam accommodations or one on one supervision could be helpful. It is important for mental health professionals in India and elsewhere to liaise with schools to advocate for these supports, as they can reduce academic pressure on the student while treatment is underway.

2. Review of Literature

The comorbidity of OCD and SLD in adolescents is a complex phenomenon with significant clinical implications. Studies have indicated that early onset OCD often presents with greater severity and is associated with a higher likelihood of comorbid neurodevelopmental disorders, including SLD. In the Indian context, research has highlighted a male predominance in OCD cases among adolescents, with common comorbidities including tics, ADHD, and learning disorders (Reddy, et al. 2022)

The intersection of OCD and SLD can lead to a unique clinical profile, where obsessive compulsive symptoms may interfere with learning processes, and learning difficulties may exacerbate anxiety and compulsive behaviors. This bidirectional relationship necessitates a comprehensive assessment and integrated intervention approach. The urban Indian adolescent population faces distinct challenges, including high academic expectations, limited mental health resources, and sociocultural stigma associated with psychiatric disorders. These factors can delay diagnosis and treatment, leading to chronicity and increased functional impairment.

2.1 Urban Indian Adolescents

India's urban centres provide a unique backdrop for understanding OCD–SLD comorbidity. Urban Indian adolescents face intense academic competition and high expectations, which can both reveal and exacerbate any underlying difficulties. The National Mental Health Survey of 2015–16 found that the prevalence of mental disorders among adolescents was about 3 times higher in urban areas (4.1%) than rural (1.5%) in India Murthy

(2017). Urban living often means greater awareness of conditions like OCD and SLD (and more resources for diagnosis), but it also means greater stressors fast paced school curricula, large class sizes, and stigma in tightly knit communities.

One relevant observation from Kerala (a relatively urbanized state) was that students with OCD had significantly more suicidal thoughts (59% vs 16%) and academic difficulties than their peers, underlining the heavy toll of the illness in a competitive academic environment (Jaisoorya et al. 2015). If that student also had an unidentified SLD contributing to poor grades, they would be under even more distress. Urban schools in India now more routinely screen for learning disabilities and have counsellors on site, which can aid in early detection of both SLD and OCD. However, implementation is inconsistent. Stigma remains a barrier: families may hesitate to label a child as “learning disabled” or “mentally ill” due to fear of discrimination in school admissions and society. This can lead to delayed help seeking until problems become severe.

2.2 Immigrant Family Backgrounds

Adolescents from immigrant families (for example, a family that has moved abroad, shifted to India in search of security and better resources and living conditions or any youth living in a country different from their parents' origin) face unique circumstances that can influence the development and management of OCD and SLD. Research has increasingly shown that migration and acculturation can impact youth mental health and developmental disorders. Immigrant children often grow up bilingual, straddling two cultures, and sometimes in lower socioeconomic or high stress environments all of which can affect learning and anxiety levels.

One consistent finding is that children of immigrants may be at higher risk for neurodevelopmental disorders in general. Several European studies noted higher rates of autism in children of immigrant mothers, and although data on SLD are less conclusive, some studies have reported higher incidence of learning disabilities in immigrant populations as well. Factors like prenatal maternal stress, limited access to prenatal care, or nutritional differences are all taken into consideration. Additionally, once in school, immigrant children might struggle if there's a mismatch between their home language and the school language, potentially leading to academic delays that either *mimic* a learning disorder or exacerbate an existing one. It's critical for evaluators to differentiate an English language learner who reads poorly because English is new to them, or in case Hindi as a part of everyday communication, from a true dyslexic child and similarly to not dismiss real learning disorders as just language issues.

When it comes to OCD in immigrant youth, cultural and migration stress can shape symptom patterns. As mentioned earlier, a study by Pozza *et al.* (2020) found that first generation immigrant children in Italy showed higher obsessional perfectionism and more compulsive checking behavior than natives. This might reflect the uncertainty and threat sensitivity that often accompany immigrant experiences (e.g., feeling the need to exert control in a new, unpredictable environment). Moreover, immigrant families may have different explanatory models for OCD symptoms some might see it as a spiritual problem or a bad habit, affecting whether and when they seek help.

2.3 Several key themes emerge from the literature

- a) Comorbid OCD and SLD can significantly worsen a youth's functional impairment, making early identification critical.
- b) Diagnostic vigilance and comprehensive assessment are required to tease apart overlapping symptoms a task aided by awareness campaigns and training in both mental health and educational systems, particularly in high prevalence urban areas.
- c) The cognitive profile of these youths often features deficits (e.g. in working memory or processing speed) that necessitate tailored therapeutic strategies and educational accommodations.
- d) Developmental and psychosocial risk factors from perinatal events to chronic stress and trauma may predispose certain children to this comorbidity, highlighting the importance of a thorough developmental history.
- e) Treatment needs to be multimodal and culturally sensitive: a combination of evidence-based OCD treatment and academic support, delivered in a coordinated way, and adapted to the family's cultural background and the child's learning style, yields the best outcomes.

3. Case Presentation

Identifying Information:

- 1) Age: 15 years
- 2) Gender: Male
- 3) Educational Status: Grade 10 student in an urban private school
- 4) Family Background: Lives with mother and younger sister; father is employed abroad

3.1 Presenting Concerns

The adolescent, a 15-year-old male, migrated to India from another country at the age of five, navigating early developmental years amidst relocation stress, family discord, and

limited financial resources. His childhood was marked by frequent disruptions, including multiple changes in school due to academic and social difficulties. He has attended four different schools, largely due to challenges including bullying, peer rejection, and negative teacher interactions, all of which have left lasting emotional and relational scars.

The child had a full-term birth with no significant prenatal or perinatal complications. Developmental milestones were achieved within normal limits. No history of significant medical illnesses was reported. The mother reported a family history of anxiety disorders on her side. The father's side was unremarkable for psychiatric conditions. Informant was his mother. His early psychological challenges began with significant familial instability and socio-environmental stressors, but his obsessive-compulsive symptoms became clinically evident at age eleven. These symptoms initially centered on cleanliness, including compulsive handwashing and persistent anxiety about contamination, which led to avoidance behaviors and even dermatological irritation. These symptoms were later diagnosed as obsessive-compulsive disorder. Since receiving pharmacological intervention, his obsessive thoughts and compulsions have significantly diminished, and he no longer presents for primary OCD treatment. He currently attends the institution specifically for diagnostic clarification and support regarding his persistent academic challenges, now understood to reflect a Specific Learning Disorder of obsessive-compulsive disorder around the age of eleven, initially manifesting as excessive concern with cleanliness, especially focused on handwashing and clothing hygiene. These compulsions escalated to the point of causing dermatological irritation, as he persistently avoided touching objects and over-engaged in washing rituals. This behavior appeared as an attempt to assert control in an otherwise unpredictable environment.

Academically, he presents with pronounced difficulties in reading and writing. His ability to interpret information from blackboards or textbooks is significantly impaired, and his written output does not align with his chronological age or expected academic level. Despite attending tuitions, his progress has remained limited. He demonstrates no receptive or expressive language deficits in speech and hearing, yet struggles severely to translate his understanding onto paper, suggestive of a specific learning disorder impacting written expression and reading fluency.

Socially, the adolescent is a self-described 'back bencher' who, despite his non-aggressive and non-disruptive demeanor, has not been able to forge supportive peer relationships. His avoidance of typical group behaviors has often made him the target of ridicule or exclusion. He previously enjoyed sports particularly football but has withdrawn from physical activities over time. Difficulties with motor coordination were also noted,

including delays in learning skills such as cycling, which may reflect underlying fine-motor and perceptual planning challenges consistent with his cognitive and adaptive profiles. These experiences, taken together, have contributed to a sense of learned helplessness and emotional withdrawal, layered atop persistent academic underachievement and the internalized burden of perfectionism. The clinical trajectory underscores the importance of viewing this adolescent's difficulties through both a neurodevelopment and trauma-informed lens.

The adolescent was referred for psychological evaluation due to persistent academic difficulties, particularly in reading and writing, and noticeable compulsive behaviors, including excessive handwashing and checking rituals. These behaviors intensified during periods of academic stress.

3.2 Assessment Results

The psychological assessment results reveal a complex profile marked by verbal strengths coexisting with notable cognitive and adaptive asymmetries. Across structured and projective measures, the adolescent demonstrates a blend of abstract reasoning capabilities and executive processing vulnerabilities.

Malin's Intelligence Scale for Indian Children (MISIC)

In the verbal domain, the adolescent exhibits high potential in abstract conceptualization and verbal reasoning, as observed in tasks that assess understanding of similarities and vocabulary depth. These abilities reflect a robust internal lexicon and the capacity to engage in logical categorization. However, areas such as sequential auditory memory, numerical reasoning, and understanding of social norms emerge as relative weaknesses. These discrepancies suggest difficulty with real-time cognitive processing and applying knowledge in ambiguous or socially nuanced scenarios.

In the performance domain, the adolescent performs more fluidly in tasks that are highly structured and rule-based, indicating relative strength in speeded visual processing and procedural learning. In contrast, tasks that demand spatial assembly, perceptual integration, and flexible problem-solving particularly under pressure pose significant challenges. These difficulties are compounded in open-ended or less scaffolded tasks where planning, cognitive flexibility, and error monitoring are essential.

The overall pattern is indicative of a high verbal-low performance asymmetry, commonly observed in adolescents with Specific Learning Disorders and perfectionistic coping tendencies. This cognitive profile suggests a reliance on verbal reasoning as a compensatory mechanism for executive functioning deficits, often exacerbated by obsessive-compulsive traits such as excessive checking and performance anxiety. These features collectively inform

a formulation of euro-cognitive vulnerability embedded within a broader internalizing spectrum.

Vineland Adaptive Behaviour Scales (VABS)

The Vineland Adaptive Behaviour Scales (VABS) were administered via caregiver interview to assess the adolescent's everyday functioning across key developmental domains. The results were converted into age-equivalent scores to better contextualise adaptive development:

- a) **Communication:** Functioning at a level equivalent to approximately 12 years, the adolescent demonstrates sufficient receptive and expressive abilities for age-appropriate comprehension and articulation. However, he exhibits marked hesitation in initiating communication in evaluative or unfamiliar settings, often relying on others to lead interactions.
- b) **Daily Living Skills:** Functioning at a level equivalent to 13 years and 6 months, the adolescent is capable of independent self-care, time management for basic routines, and organizing school-related materials. However, task persistence and spontaneous initiative can vary depending on emotional state and perceived expectations.
- c) **Socialization:** Functioning at an age-equivalent of 12 years and 7 months, difficulties are apparent in initiating peer interaction, asserting preferences, and navigating unstructured social environments. Social withdrawal and over compliance suggest internalised fears of criticism or failure, commonly associated with perfectionistic tendencies and OCD-related cognitive patterns.
- d) **Motor Skills:** These were assessed to be at par with chronological age, indicating intact gross and fine motor abilities. Minor issues arose only under tasks requiring simultaneous cognitive and motor coordination, potentially linked to executive function inefficiencies rather than core motor delays.

The VABS profile reveals that while the adolescent possesses the foundational skills necessary for age-appropriate adaptive functioning, emotional inhibition and anxiety-related withdrawal may suppress full expression of these competencies, particularly in socially evaluative or novel contexts. These findings align with the broader clinical picture of a perfectionistic, over regulated adolescent coping with both neuro-developmental and internalizing Vulnerabilitäten.

Projective Tests Draw-A-Person and Children's Apperception Test (CAT)

The DAP protocols revealed a strong structural sense with proportionate but emotionally bland representations. The drawings lacked facial expressiveness and

interpersonal nuance, suggesting affective inhibition and guardedness. In the CAT responses, themes of loneliness, pressure to perform, and emotional passivity were recurrent. Characters tended to be compliant and lacking in agency, mirroring the adolescent's real-life difficulties with assertiveness and autonomy. The narratives contained minimal aggression or problem-solving, consistent with an internalised coping style and potential perfectionistic self-concept.

Behavioural Observations and Task Engagement

During assessment tasks, the adolescent showed high motivation and cooperation but required frequent reassurance. He appeared anxious about making errors, often rechecking his responses even when told to proceed. In writing tasks, there was a noticeable latency and hesitancy, reflecting both obsessive doubt and graphomotor inefficiency. His performance declined on speeded tasks requiring sustained visuomotor attention. These behaviors align with residual OCD patterns particularly perfectionism and checking as well as executive delays associated with SLD.

3.3 Diagnostic Summary

These comprehensive assessment findings support the dual diagnosis of:

- a) Obsessive-Compulsive Disorder (residual symptoms of contamination and checking, high perfectionism) (managed under medication)
- b) Specific Learning Disorder with impairments in written expression and reading fluency

Clinical Progress Plan

The primary goal is to address both OCD and SLD through a multidisciplinary approach involving psychotherapy, educational support, and family involvement.

Domain	Intervention	Details / Strategies
Psychotherapeutic	Cognitive-Behavioral Therapy (CBT)	ERP modules tailored to reduce compulsions and anxiety, especially academic-related rituals.
	Cognitive Remediation Therapy	Focused on improving executive functioning: working memory, planning, and flexibility.
Educational	Individualized Education Plan (IEP)	Collaboratively developed with school to provide accommodations like extended time, assistive tech, and reduced workload.

	Specialized Tutoring	Multisensory strategies for reading and writing remediation, targeting fluency and comprehension.
Family-Based	Psychoeducation	Educating the mother about OCD and SLD, emphasizing consistent routines, reduction of overaccommodation, and positive reinforcement strategies.
	Parenting Strategies	Training in authoritative parenting with balanced warmth and structure, minimising reinforcement of compulsions.
Classroom Accommodations	Flexible Scheduling	Allowing short breaks during tasks to manage stress and sensory overwhelm. Permit alternative deadlines under stress-inducing conditions (e.g., exams).
	Alternative Assessments	Use of oral presentations, MCQs, and project-based formats in lieu of extensive writing.
	Collaborative Communication	Ongoing triadic discussions between teachers, parents, and counsellors to monitor and adapt strategies. Requesting to avoid public reprimands and use of discreet communication
	Visual and Written Instructions	Tasks broken into smaller, clearer steps with visual aids and checklists. Avoid reliance solely on verbal or blackboard instructions.

Parental Guidance	Structuring Home Environment	Establishing consistent, predictable routines and task schedules
	Emotional Support	Encouraging open, non-judgmental discussions about his challenges and anxieties.
	Stress Management	Mother–child dyadic relaxation practices (e.g., yoga, mindfulness, deep breathing).
	Community Linkages	Referrals to parent support networks, workshops on neurodevelopmental disorders, and culturally sensitive resources for immigrant families.

3.4 Prognosis

With early identification and a comprehensive intervention plan, the prognosis for adolescents with comorbid OCD and SLD is generally favorable. Success is contingent upon consistent therapeutic engagement, educational accommodations, and robust family support. Ongoing monitoring and flexibility in interventions are essential to adapt to the adolescent's evolving needs. In the domain of learning, gains may be slower but meaningful, especially if academic expectations are adjusted and executive remediation is implemented early. The adolescent may continue to require supportive accommodations through secondary education, with gradual transitions toward independent functioning guided by therapeutic scaffolding.

Key factors that will influence long-term outcomes include

- a) Continuity of therapy with an experienced child psychologist trained in OCD and learning disorders.
- b) Regular monitoring of academic stressors and transition points (e.g., examinations, school change).
- c) Sustained caregiver engagement, particularly in supporting emotional growth over performance.
- d) Prevention of relapse through periodic booster sessions and a graduated exit plan from formal therapy.

4. Conclusion

This case presents a detailed examination of how deeply rooted internal conflict and invisible barriers can manifest in the life of a high-functioning adolescent. Initially referred for underachievement, the case gradually unfolded to reveal a web of obsessive-compulsive perfectionism, masked executive dysfunction, and long-standing academic impairment. With a background marked by early migration, family instability, and repeated school changes, the adolescent's experiences offered insight into how environmental disruption intersects with neuro-developmental vulnerability. It also exemplifies the nuanced clinical realities of working with adolescents who present with intersecting neuro-developmental and emotional disorders within a socio-culturally complex family context. The co-occurrence of OCD and SLD in this adolescent underscores the importance of integrating cognitive, emotional, familial, and cultural dimensions in case conceptualization. The intervention pathway spanning therapeutic engagement, executive remediation, school accommodations, and caregiver psychoeducation demonstrates the necessity of systemic collaboration in youth mental health care. This case also reaffirms the critical role of maternal presence, educator sensitivity, and culturally competent approaches in supporting the autonomy and well-being of adolescents with invisible disabilities. From an ethical standpoint, all clinical assessments and interventions were designed with informed consent from the primary caregiver. Confidentiality was maintained throughout the evaluation and documentation process, and institutional affiliations or clinician identities have been anonymized in this academic presentation. Cultural sensitivity and psychological safety were prioritized in all interactions. The therapeutic strategy was tailored to the adolescent's developmental stage and psychological readiness, ensuring non-maleficence and emotional containment. This case offers valuable insights for clinicians, educators, and policymakers working with adolescents in transitional urban ecosystems, and highlights the need for accessible, multidimensional mental health support systems that can address not only pathology but also potential.

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