

# WHAT IS OBSESSIVE-COMPULSIVE DISORDER?



**BASIC FACTS • SYMPTOMS • FAMILIES • TREATMENTS**



Mental Illness Research, Education and Clinical Center  
VA Desert Pacific Healthcare Network  
Long Beach VA Healthcare System  
Education and Dissemination Unit 06/116A  
5901 E. 7th Street | Long Beach, CA 90822

## basic facts

Obsessive-compulsive disorder (OCD) is a psychiatric disorder characterized by the presence of obsessions and/or compulsions. Obsessions are repeated thoughts, images, or urges that are unwanted and cause significant distress and anxiety. Compulsions are repetitive behaviors or mental acts that a person feels like they need to do, usually in response to an obsession. People's experiences of OCD vary greatly in terms of specific symptoms. For example, one person might be excessively concerned with germs or contamination and spends excessive amounts of time washing or cleaning, whereas another person might have disturbing violent or sexual images that they struggle to control. Some might count in their heads compulsively to try to counteract "bad" thoughts or impulses, whereas others struggle to leave the house because checking the locks or the stove becomes the focus of their attention.

*OCD is characterized by the presence of obsessions and/or compulsions. People's experiences of OCD vary greatly in terms of specific symptoms.*

### Prevalence

Between 2-3% of people will have OCD at some point during their lifetime. Virtually everyone experiences occasional unwanted thoughts and does ritualistic behavior from time to time. However, it is also very common to experience OCD symptoms and not meet full criteria for the disorder. One large-scale study found that over a quarter of people reported experiencing obsessions and/or compulsions at some point in their lifetime, but their symptoms were not severe enough to warrant an OCD diagnosis. Females experience OCD at a slightly higher rate than males, and the disorder is found across all levels of education and income. The prevalence rates internationally are similar to that of the U.S.

*Between 2-3% of people will have OCD at some point in their lifetime, but many more people will experience OCD symptoms and not meet full criteria for the disorder.*

### Course of OCD

The average age of onset in the U.S. is late teens/early 20's. However, OCD can begin as early as childhood, and about a quarter of cases emerge before age 14. An earlier age of onset is more common in males. If left untreated, OCD tends to be a chronic condition, often with symptom severity fluctuating over time. Some people might experience acute OCD episodes during times of stress, but then the symptoms remit after a period of time. Both pregnancy and the postpartum period are associated with an increased risk of developing OCD or a worsening of symptoms for women with a history of OCD. Most people with OCD also have at least one co-occurring disorder. OCD tends to co-occur with anxiety or mood disorders.

*The average age of onset of OCD is late teens/early 20's. However, it can begin as early as childhood. Most people with OCD also have at least one co-occurring disorder.*

### Causes

There is no simple answer to what causes OCD because several factors may play a part in the onset of the disorder. These might include a genetic or family history of OCD or other anxiety disorders, biological factors, psychological vulnerability, life events, and environmental stressors.

Although there is not an "OCD gene," and much is unknown about the role of genes in the development of OCD, it is likely that multiple genes contribute to the development of the disorder. It is thought that genes play a greater role in people who have OCD symptoms at a younger age.

In addition to genetics, many scientists believe that there is a biological contribution to the development and maintenance of OCD, such as an imbalance in brain chemicals (e.g., glutamate). Further, brain imaging studies have found that people with OCD have differences in brain structure and abnormal functioning in brain circuits, as compared to those without the disorder. For some females, hormones appear to be strongly related to OCD; onset and



worsening of symptoms are related to menstruation, pregnancy, and the postpartum period.

There are several personality factors that increase a person's risk of developing OCD. Individuals with a more anxious temperament are at increased risk. The way a person responds to distressing thoughts can also be a risk factor. It is normal for everybody to have out-of-character and intrusive thoughts from time to time. For example, a person may have violent thoughts or distressing sexual impulses. While most people can dismiss these thoughts easily, those who go on to develop OCD tend to worry and make meaning of these thoughts, leading to the development of obsessions. Other personality factors that are associated with the development of OCD are tendencies to be overly superstitious, excessively guilty, or highly moralistic. For example, people who tend to experience a lot of guilt have difficulty dismissing upsetting, intrusive thoughts. Instead, they might try to actively suppress the thought or behave in ways to counteract it (compulsions). Similarly, those who are highly moralistic and have a strong sense of right and wrong might also have difficulties dismissing a thought that they perceive as bad (e.g., a blasphemous religious thought).

None of these risk factors alone are likely the sole cause of OCD. Stressful life events and environmental factors are often contributors as well. These factors can include childhood loss, trauma, or abuse or stressful life events as an adult. Stressful life events include negative events such as a death of a loved one, divorce, financial stress, or loss of a job. They can also include significant positive life events, such as getting married, having a baby, or getting promoted at work. Stressful events do not appear to cause OCD but can worsen symptoms significantly.

In sum, although it is unclear exactly how OCD is caused, there are many possible factors that could play a role; these factors are likely to be different for different people. It is important to keep in mind that there are effective treatments for OCD even though the cause is not completely understood.

*Although much is unknown about how OCD is caused, risk factors might include a genetic or family history of OCD or other anxiety disorders, biological factors, psychological vulnerability, life events, and environmental stressors.*

## diagnosis and symptoms

OCD cannot be diagnosed with a blood test, CAT-scan, or any other biological or laboratory test. The only way to diagnose OCD is with a clinical interview, in which the interviewer will ask about the symptoms of OCD and the degree of related distress and interference. A physical exam is also important to rule out medical causes for the symptoms.

An OCD diagnosis is characterized by the presence of obsessions and/or compulsions. The majority of people with an OCD diagnosis have both types of symptoms, but there are some who have just one or the other. Obsessions are defined as recurrent and persistent thoughts, urges, or images that a person experiences as unwanted and intrusive. These usually cause a high degree of distress or anxiety. Obsessions are usually accompanied by attempts to get rid of them, either through ignoring, suppressing, or neutralizing with another thought, or by performing a compulsion. Compulsions are repetitive behaviors (e.g., hand washing and lock checking) or mental acts (e.g., counting or repeating words) that a person feels compelled to do. Compulsions are often in response to an obsession or to a set of rigid rules individuals have set for themselves. Compulsions are usually done to reduce anxiety or distress or to prevent some horrible perceived outcome from occurring. The compulsive act is not always logically related to the obsession. For example, a person might count to counteract the intrusive thought of harming others. If the compulsion is related to the obsession, such as checking the stove to counteract fears of a fire, the compulsion must be excessive to be considered a symptom.

To be diagnosed with OCD, these symptoms must be severe enough to interfere with a person's day-to-day functioning, cause significant distress, and/or be very time-consuming (at least one hour a day). Further, these symptoms cannot be due to the effects of a substance or another medical condition and cannot be better explained by another mental health disorder.

*The only way to diagnose OCD is with a clinical interview, in which the interviewer will ask about the symptoms of OCD and the degree of related distress and interference.*





## similar psychiatric disorders

There are a few psychiatric disorders that mental health professionals consider to be related to OCD because of their overlap in symptoms, course of illness, and risk factors. Repetitive behaviors are also a component of these disorders. For example, hoarding disorder is characterized by a compulsive collection of belongings and extreme difficulty in discarding them, resulting in a lot of clutter in one's surroundings. A person with obsessions and compulsions that are solely related to an aspect of their appearance might be diagnosed with body dysmorphic disorder. Trichotillomania (compulsive hair pulling) and excoriation (skin picking) are also considered to be OCD-related disorders. These related disorders, however, are not necessarily treated the same way that OCD is treated.

OCD also shares symptoms with non-related psychiatric disorders. If a person's obsessions are solely surrounding food and weight, an eating disorder might be diagnosed. Generalized anxiety disorder is characterized by excessive

worry, which might seem similar to an obsession. The difference is that with generalized anxiety disorder, the worries tend to be about real life concerns, while obsessions tend to be less realistic and more unusual. Major depressive disorder is often characterized by ruminations which also may seem similar to obsessions. Ruminations, however, tend to be less distressing and intrusive than obsessions. Tic disorder, which is sometimes confused with OCD, is characterized by sudden and rapid motor movements or vocalizations. Tics differ from OCD compulsions in that tics are often experienced as being involuntary and occur very quickly. Compulsive behaviors are also seen in several other mental health disorders, such as alcohol or substance use disorders.

*There are a few psychiatric disorders that mental health professionals consider to be related to OCD because of their overlap in symptoms, course of illness, and risk factors. OCD also shares symptoms with non-related psychiatric disorders.*

## treatment

Different types of treatments are available for people with OCD, including medications and psychotherapy. For those with a milder case of OCD, psychotherapy alone might be effective, while those with more severe symptoms might also benefit from medications. For many, a combination of the two might be most effective. The treatments listed here are ones which research has shown to be effective for people with OCD. They are considered to be evidence-based practices.

### Medication

The section called "Medications for OCD: What You Should Know" (pages 6-7) provides information about medications used to treat OCD.

### Cognitive Behavioral Therapy (CBT)

Research shows that cognitive behavioral therapy (CBT) is the most effective treatment for OCD. CBT is a blend of two types of therapies: cognitive therapy and behavioral therapy and can be delivered in an individual or group format. Family members can also be involved in the treatment and can help reinforce treatment concepts. CBT starts with a thorough assessment of symptoms. Using information from the assessment, the therapist will then provide education about OCD and tailor it to the person's specific symptoms. Specifically, the therapist will address how obsessions develop and are maintained, and how OCD behaviors (compulsions, reassurance-seeking, and avoidance) feed into the OCD cycle.

The cognitive therapy component of CBT focuses on a person's thoughts and beliefs and is often used to help people with OCD change how they think about their obsessional thoughts. For example, if a person believes that they will act on their disturbing obsessional thoughts, the therapist will help them see that having a thought about sex or violence is not the same thing as acting immorally or violently.

The behavioral component of CBT, exposure and response prevention (ERP), is a key component of treatment. This intervention involves helping people to gradually confront what they are afraid

of, such as leaving their home unlocked, and then helping them resist the urge to engage in the compulsion, in this case repeatedly checking the lock. Exposures can be done in the actual situation (in vivo) and/or through imagination. ERP can be very uncomfortable and anxiety-producing. However, with repeated exposure to feared thoughts and situations, combined with resisting compulsive behaviors, people learn that they can tolerate the anxiety and distress and will eventually experience a decrease in OCD symptoms. To get more practice doing exposures, people are often instructed to do exposure between sessions as therapy homework.

Many people with OCD ask others for reassurance (e.g., "Is the door locked" or "Am I a bad person?"). In CBT, the person will learn about how reassurance contributes to the OCD cycle. They will be asked to refrain from reassurance-seeking so they can learn to tolerate their anxiety.

### Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) is a newer treatment that has been used for OCD. There has been limited research on ACT and OCD, but the studies that have been conducted thus far are promising. An overarching goal of ACT is to help people identify what they value most in their lives, such as family, work, social relationships, and community, and help them take action to support living in line with these values. In ACT, people focus on accepting their unpleasant obsessions rather than fighting against them. People practice disengaging from the obsessive thoughts and learn that having negative thoughts does not reflect badly on who they are as a person. ACT also uses mindfulness to be more present. People who regularly practice mindfulness can learn to be less judgmental and reactive, and more accepting of their negative thoughts and emotions. Mindfulness can teach people with OCD to simply observe their symptoms, rather than feeding into them with fearful thoughts, compulsions, and avoidance behaviors.

*Cognitive behavior therapy is the most effective psychosocial treatment for OCD. There is recent research that supports a newer treatment called acceptance and commitment therapy.*

## Encourage Treatment

OCD is a treatable problem. Psychotherapy (especially CBT) and medications can help alleviate the symptoms of OCD and allow a person to regain control over their life. It is important for a person with OCD to first visit a mental health professional for a thorough evaluation. If possible, family members could also attend to help answer questions and to provide support. If the person with OCD is prescribed medications that need to be taken at regular times, the family member can help give support around that. Taking medication can be difficult – there might be times when a person does not want to take it or just might forget to take it. Family members can help encourage and remind them to take their medications. Family members can also support attendance to psychotherapy appointments by giving reminders and providing transportation to the clinic.

## Eliminate Accommodation and Reinforce Treatment Concepts

OCD can affect the entire family. Family members often engage in accommodation of their relative's OCD symptoms. Accommodation refers to assisting with rituals/compulsions, providing reassurance, helping with avoidance behaviors, and/or changing of personal and family routines due to the OCD. Although family members might feel like they are "helping" their relative by making these types of accommodations, these behaviors actually make things worse. In fact, research has found that the greater the family accommodation, the more severe the OCD symptoms. These types of behaviors reinforce the OCD cycle, and the affected family member does not learn how to tolerate anxiety associated with the OCD. How can family members eliminate accommodation? For example, when asked by their relative with OCD for reassurance, family members can gently say, "you are asking for reassurance, and I'm not going to give it to you because it feeds into the cycle of OCD." In families where plans often change because of OCD be-

haviors (e.g., due to time spent on compulsions), family members can insist that plans must go on as scheduled regardless of urges to do compulsions.

Family members often feel guilty about not accommodating their relative's symptoms, but having an understanding of the cognitive-behavioral model of OCD can help reduce feelings of guilt. If their relative is receiving CBT, family members can talk with the therapist to learn specifics about how they can reduce accommodation and provide support of the treatment. For example, CBT is comprised of homework assignments; family members can encourage their relative to engage in the homework, such as exposure practice, and offer to help, if relevant. If mindfulness is part of the treatment, family members can offer to join in such practice at home. Even if a person is not receiving psychotherapy for OCD, relatives can help reinforce some of these concepts by eliminating accommodation and encouraging exposure.

## Take Care of Themselves

Given the challenges that family members may face, it is important that they take care of themselves as well. There are many ways to do this. Family members should not allow their relative with OCD to monopolize all of their time, and spending time alone or with other family members or friends is important for their own well-being. Family members may also consider joining a support or therapy group. Counseling can often help family and friends better cope with a loved one's OCD. Finally, family members should not feel responsible for solving the problem themselves. They can't. They should get the help of a mental health professional if needed.

*Family members can help their relative with OCD by encouraging treatment, eliminating accommodation, and reinforcing treatment concepts. Family members should also remember to take care of themselves.*





## medication: what you should know

- There are different types of medications that are effective for OCD. The primary medications used for OCD are serotonin reuptake inhibitors (SRIs), a specific class of antidepressant medications. These include both the selective serotonin reuptake inhibitors (SSRIs) and the tricyclic antidepressant clomipramine, which also has strong SRI properties. The doses of SRI medications that are needed for treatment of OCD are considerably higher than those used for treatment of depression or other anxiety disorders. There is some evidence for serotonin-norepinephrine reuptake inhibitors (SNRIs), but they have not been FDA-approved for treatment of OCD, and are therefore considered second-line treatments. Other antidepressants that are *not* SRIs are not effective.
- For patients whose OCD symptoms do not respond well to SRI medications, other medications are often added, such as second generation antipsychotics and glutamate modulators. These medications are not effective for OCD when used alone, but they can be helpful when added to SRIs.
- These medications work on neurotransmitters believed to regulate anxiety and mood, including serotonin, dopamine, and glutamate.
- Sometimes the medication you first try may not lead to significant improvements in your OCD symptoms. What works well for one person may not do as well for another. Be open to trying another medication or combination of medications to find a good fit. Let your doctor know if your symptoms have not improved and do not give up searching for the right medication or combination of medications!
- All medications may cause side effects, but many people have no side effects or minor side effects. The side effects people typically experience are tolerable and subside in a few days. Check with your doctor if side effects persist or become bothersome. In rare cases, these medications can cause severe side effects. Contact your doctor immediately if you experience one or more severe symptoms.



**This handout provides only general information about medication for obsessive-compulsive disorder. It does not cover all possible uses, actions, precautions, side effects, or interactions of the medicines mentioned. This information does not constitute medical advice or treatment and is not intended as medical advice for individual problems or for making an evaluation as to the risks and benefits of taking a particular medication. The treating physician, relying on experience and knowledge of the patient, must determine dosages and the best treatment for the patient.**





## Antipsychotic Medications

- Although OCD is not a psychotic disorder, adding antipsychotic medications to ongoing treatment with SRIs can sometimes be helpful in reducing OCD symptoms. They are reserved for patients who do not have a good response to SRI medications and are usually prescribed in low doses.
- All antipsychotic medications must be taken as prescribed. They often take several weeks to have their full effect on OCD symptoms. It is important that you don't stop taking your medication because you think it's not working. Give it time!
- Most antipsychotics are prescribed once daily. If you forget to take your medication, do not double up the next day to "catch up" on the dose you missed. If your medication is prescribed to be taken twice a day, here is a safe rule of thumb if you forget to take a dose: if it has been *six hours or less* from the time you were supposed to take your medication, take your medication. If it has been *more than six hours* after the dose should have been taken, just skip the forgotten dose and resume taking your medication at the next regularly scheduled time. *Never double up on doses of your antipsychotic to "catch up" on those you have forgotten.*

## Antidepressant Medications

- SRI medications must be taken at full, anti-obsessional doses for up to 12 weeks before you can expect to see positive changes in your symptoms. So don't stop taking your medication because you think it's not working. Give it time!
- Once you have responded to treatment, it is important to continue treatment. It is typical for treatment to continue for 1-2 years. Discontinuing treatment earlier may lead to a relapse of symptoms. If you have a more severe case of OCD, the doctor might recommend longer term treatment.
- To prevent OCD symptoms from coming back or worsening, do not abruptly stop taking your medications, even if you are feeling better. Stopping your medication can cause a relapse. Medication should only be stopped under your doctor's supervision. If you want to stop taking your medication, talk to your doctor about how to correctly stop it.
- Here is a safe rule of thumb if you miss a dose of your antidepressant medication: if it has been *three hours or less* from the time you were supposed to take your medication, take your medication. If it has been *more than three hours* after the dose should have been taken, just skip the forgotten dose and resume taking your medication at the next regularly scheduled time. *Never double up on doses of your antidepressant to "catch up" on those you have forgotten.*

### ATYPICAL ANTIPSYCHOTICS

Aripiprazole (Abilify)  
 Risperidone (Risperdal)  
 Olanzapine (Zyprexa)  
 Quetiapine (Seroquel)  
 Ziprasidone (Geodon)

### FIRST-GENERATION ANTIPSYCHOTICS

Haloperidol (Haldol)  
 Fluphenazine (Prolixin)



### SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)

Citalopram (Celexa)  
 Escitalopram (Lexapro)  
 Fluoxetine (Prozac)  
 Fluvoxamine (Luvox)  
 Paroxetine (Paxil)  
 Sertraline (Zoloft)

### SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)

Desvenlafaxine (Pristiq)  
 Venlafaxine (Effexor)

### TRICYCLICS AND TETRACYCLICS (TCAs AND TECAs)

Clomipramine (Anafranil)





**MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER**

VA Desert Pacific Healthcare Network  
Long Beach VA Healthcare System  
Education and Dissemination Unit 06/116A  
5901 E. 7th Street  
Long Beach, CA 90822

**VISIT US ON THE INTERNET AT:**

<http://www.mirecc.va.gov/visn22>

**DOWNLOAD THIS HANDOUT AT:**

[http://www.mirecc.va.gov/visn22/ocd\\_education.pdf](http://www.mirecc.va.gov/visn22/ocd_education.pdf)

Bonnie Zucker, PhD <sup>1</sup>

Noosha Niv, PhD <sup>1,2</sup>

Jonathan Abramowitz, PhD <sup>3</sup>

Sanjaya Saxena, MD <sup>4</sup>

<sup>1</sup>VA Desert Pacific Mental Illness Research, Education and Clinical Center (MIRECC)

<sup>2</sup>UCLA, Department of Psychiatry and Biobehavioral Sciences

<sup>3</sup>UNC-Chapel Hill, Department of Psychology and Neuroscience

<sup>4</sup>UCSD Department of Psychiatry