Obsessive Compulsive Disorder Fact Sheet

Definition and prevalence. OCD is a psychiatric condition characterized by persistent, recurring, and unwanted intrusive (involuntary) thoughts, images, memories, and/or urges (obsessions) and repetitive behaviors or mental acts (compulsions) aimed at reducing the anxiety or distress caused by intrusive thoughts. Common obsessions in youth include fears of contamination, disease, or causing harm; sexual fears; doubting/what ifs; thinking something must be done a certain way to feel just right or to avoid harm; hoarding; and religious or scrupulosity fears. Common neutralizations include washing, checking, counting, redoing, doing things a certain way/number of times, praying, evening, hoarding, and seeking reassurance. Compulsions work by temporarily reducing anxiety, but the urge to perform the neutralization gets stronger with repetition. OCD thereby becomes a vicious cycle with neutralizations required to provide relief from the unwanted obsessions. The current estimated prevalence of 0.25%–4% among children and adolescents. While symptoms tend to flare and retreat over time, the disorder is chronic and can cause marked functional impairment across multiple domains, including at home, school, and socially.

Diagnosis and differentiation. Many children have routines or rituals that are completely normal and transient. It is important to differentiate between these typical behaviors and true neutralizations or compulsions, which are distressing or functionally impairing. The earlier that OCD is detected and diagnosed, the better the likely outcome of treatment. However, delays in detection in youth occur because of difficulty parsing out normal routines from OCD, lack of insight about symptoms, embarrassment and secretiveness around symptoms, and heterogeneity of symptoms.

Etiology and cause. The exact causes of OCD are yet unknown, but research suggests OCD arises from a problem with how the brain processes information. OCD appears to come from a biochemical imbalance that results in an overestimation of threat and underestimation of coping. Neuroimaging studies demonstrate brain activation consistent with threat overestimation and intolerance. And neuroimaging following ERP shows a decrease in this activation through changes in processing information and subsequent changes in neuroactivity. There is also evidence that OCD comprises a learned response to reduce anxiety through compulsive behaviors, sometimes triggered by a stressful event. However, the heritability factor of pediatric OCD appears greater than in adult onset cases.

Treatment. The two evidence-based treatments for pediatric OCD are SSRI medication and ERP. For some youth the combination of the two is most helpful. Medication without ERP does not produce the same long-term effects as ERP or the combination.

Support for youth with OCD. Families and teachers can serve as highly important supports for youth with OCD by both cheering them on to fight back against OCD themselves and by resisting youths' attempts to engage trusted others in neutralizations or compulsions. Being part of the solution can be achieved through partnership and communication with the youth's clinician.