

## OBSESSIVE-COMPULSIVE DISORDER AND SUBSTANCE USE DISORDERS

Obsessive-compulsive disorder (OCD) is a mental disorder characterized by intrusive, obsessive thoughts and compulsive, repetitive behaviors that often significantly interfere with work, school, relationships, and other activities and responsibilities.<sup>1</sup> In fact, the World Health Organization has cited OCD as being one of the top 10 causes of disability worldwide.<sup>2</sup>

OCD frequently co-occurs with substance use disorders (SUDs).<sup>3,4,5,6,7</sup> Individuals with co-occurring OCD and SUDs may have a greater level of impairment in overall psychosocial functioning than individuals with OCD but without an SUD.<sup>4</sup> Individuals who have both conditions may also have an increased risk for suicidality.<sup>4,8,9</sup> Research indicates that some individuals with OCD may develop SUDs as a method of coping with their OCD symptoms.<sup>4,10,11,12</sup> When an SUD and OCD co-occur, both conditions need to be addressed because the consequences, assessment, treatment, and recovery can be more complicated for each disorder when they occur together.

Because SUDs may sometimes develop as a way of coping with OCD symptoms, substance use counselors may be in a good position to help clients with undiagnosed OCD. Counselors need to understand OCD and OCD treatments so they can:

- Recognize possible OCD symptoms.
- Screen clients for possible OCD.
- Make appropriate referrals for professional assessment, diagnosis, and evidence-based OCD treatments.
- Help clients with co-occurring OCD and SUDs attain and maintain SUD recovery by understanding (and helping clients understand) how the presence of each disorder can affect the course and treatment of the other.

The goals of this *Advisory* are to raise counselors' awareness of OCD and its relationship to SUDs and to

provide an overview of screening and evidence-based treatments for OCD. The *Advisory* does not provide comprehensive how-to information on treating clients with OCD. For more information, see the Resources section.

### What Is OCD?

Exhibit 1 presents the diagnostic criteria for OCD listed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5).<sup>1</sup>

Some of the more common types of OCD obsessions and compulsions (i.e., symptoms) are presented in Exhibits 2 and 3; however, these lists are far from exhaustive. Some studies have found gender differences in OCD symptoms. For example, symptoms related to sex and religion tend to be more common in men, and contamination- and cleaning-related symptoms tend to be more common in women.<sup>13,14</sup>

Individuals with OCD often have dysfunctional beliefs (e.g., about the power of their thoughts or the necessity of perfection) and varying degrees of insight into the validity of these beliefs. For example:<sup>1</sup>

- Individuals with good or fair insight realize that their OCD beliefs are definitely or probably not true.
- Individuals with poor insight think that their OCD beliefs are most likely true.
- Individuals with no insight are certain that their OCD beliefs are true.

### How Common Is OCD?

Lifetime prevalence estimates for OCD in the United States range from 1.6 percent<sup>15</sup> to 2.3 percent.<sup>6\*</sup> The prevalence is slightly higher for adult females, although males are more likely to have OCD in childhood.<sup>1,6,14</sup>

\* Differences in estimated prevalence may reflect differences in diagnostic methods or survey types, or other methodological issues.<sup>3,4,6</sup>

# ADVISORY

## Exhibit 1. DSM-5 Diagnostic Criteria for OCD<sup>1</sup>

### A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

### B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

### C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

### D. The disturbance is not better explained by the symptoms of another mental disorder.

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## What Is the Relationship Between OCD and SUDs?

Estimates of the lifetime prevalence of a co-occurring SUD in individuals with OCD vary widely, from less than 10 percent<sup>16</sup> to almost 40 percent,<sup>6</sup> depending on various factors.<sup>†</sup> However, it has been reported that fewer than half of individuals with co-occurring OCD and SUDs seek treatment for their OCD.<sup>5</sup> In addition, even seasoned clinicians may misdiagnose individuals with OCD symptoms, particularly symptoms involving taboo sexual thoughts.<sup>17</sup> These findings suggest that rates of co-occurrence may be higher than current estimates and that OCD often goes untreated.

Although OCD and SUDs are classified as clinically distinct, both are associated with high levels of compulsive behavior.<sup>3,18,19</sup> However, there are important differences between the compulsive behaviors of SUDs and OCD. Individuals may experience a compulsion to drink

alcohol excessively or use drugs illicitly, but they tend to continue substance use because they derive some pleasure from the behavior and may only wish to discontinue the behavior because of the problems it causes in their lives. Individuals with OCD perform compulsive behaviors in response to obsessive thoughts in an effort to relieve the distress of these thoughts or out of the unrealistic belief that something bad will happen if they do not perform the compulsive behaviors.<sup>1</sup>

## What Is the Relationship Between OCD and Other Mental Disorders?

Studies have found that 90 percent or more of individuals with OCD meet lifetime criteria for at least one other diagnosable mental or substance use disorder.<sup>6,20</sup> The mental disorders with the highest rates of co-occurrence (lifetime prevalence) in people with OCD include:

- **Depression**—Estimates of lifetime co-occurrence range from 45.9 percent<sup>5</sup> to 68.4 percent.<sup>14</sup>

<sup>†</sup> OCD and SUD co-occurrence rates vary considerably for various reasons. For example, studies indicating a high level of co-occurring OCD and SUDs tend to draw participants from community samples. Studies that use individuals being treated for a primary diagnosis of OCD (whose OCD symptoms may be more severe) tend to show a lower level of co-occurrence of OCD and SUDs.<sup>10,16</sup>

### Exhibit 2. Common Obsessions<sup>21</sup>

Type	Examples
Aggressive impulses	Images of hurting a child or parent
Contamination	Becoming contaminated by shaking hands with another person
Need for order	Intense distress when objects are disordered or asymmetric
Religious	Blasphemous thoughts, concerns about unknowingly sinning
Repeated doubts	Wondering if a door was left unlocked
Sexual imagery	Recurrent pornographic images

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### Exhibit 3. Common Compulsions<sup>21</sup>

Type	Examples
Checking	Repeatedly checking locks, alarms, appliances
Cleaning	Handwashing
Hoarding*	Saving trash or unnecessary items
Mental acts	Praying, counting, repeating words silently
Ordering	Reordering objects to achieve symmetry
Reassurance-seeking	Asking others for reassurance
Repetitive actions	Walking in and out of a doorway multiple times

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\*DSM-5 defines hoarding as a separate condition, distinct from OCD.<sup>1</sup>

- **Generalized anxiety disorder**—Estimates of lifetime co-occurrence range from 31.9 percent<sup>5</sup> to 34.6 percent.<sup>14</sup>
- **Social phobia**—Estimates of lifetime co-occurrence range from 17.3 percent<sup>7</sup> to 36.1 percent.<sup>14</sup>
- **Specific phobias**—Estimates of lifetime co-occurrence range from 15.1 percent<sup>7</sup> to 33.0 percent.<sup>14</sup>
- **Panic disorder**—Estimates of lifetime co-occurrence range from 12.8 percent<sup>5</sup> to 20.2 percent (panic disorder and/or agoraphobia).<sup>14</sup>
- **Posttraumatic stress disorder**—Estimates of lifetime co-occurrence range from 11.6 percent<sup>5</sup> to 19.2 percent.<sup>14</sup>

The high incidence of co-occurring disorders makes clear how valuable integrated treatment programs can be. Integrated treatment allows for the treatment of the whole person—including medical and medication issues, mental disorders, and SUD treatment as necessary (see Resources for more information). When integrated treatment is not available, collaboration between providers becomes even more important. For example, clients may see behavioral health practitioners more frequently than they see medical practitioners; consequently, behavioral health practitioners may become aware first of new symptoms, medication side effects, or other problems requiring medical attention.

## What Information Do Substance Use Treatment Counselors Need About OCD Screening?

Substance use counselors can identify clients with possible OCD symptoms; make appropriate referrals for professional assessment, diagnosis, and evidence-based OCD treatments; and help clients with both OCD and SUDs attain and maintain SUD recovery. Exhibit 4 presents examples of the kinds of questions that might be used to elicit information on the presence of OCD symptoms.

The Anxiety and Depression Association of America offers a free online OCD screening tool on its website (see Resources). Although the screening tool does not provide a score or interpretation, the instructions suggest that individuals who complete the tool print it out and take it with them when they visit a medical or behavioral health practitioner. Responses to the screening tool questions may help inform conversations between practitioners and their clients about OCD symptoms. In addition to asking about OCD symptoms, this brief screening tool includes questions about depression and substance use.

# ADVISORY

## Exhibit 4. Questions That Might Elicit Information on the Presence of Obsessions or Compulsions<sup>1</sup>

**Obsessions**—Do you have disturbing and unwanted thoughts, such as:

- Thoughts of being contaminated?
- Images of a violent attack or catastrophic accident happening to you or someone else?
- Urges to attack someone?

**Compulsions**—Do you feel driven to do things that you don't want to do, such as:

- Repeat a behavior (such as washing your hands over and over again)?
- Check things repeatedly (such as checking the lock on your door many times before leaving home)?
- Count or arrange items repeatedly (such as putting items in a certain order or pattern until they feel “right”)?

Because OCD shares many symptoms with other mental disorders, such as anxiety disorders and major depressive disorder,<sup>1</sup> distinguishing between OCD and other mental disorders is a task for an experienced, licensed mental health practitioner. Any client who screens positive for OCD—or, in fact, any mental disorder—will need to be referred for an assessment by a behavioral health practitioner licensed to diagnose and treat mental disorders. The same is true for clients who are not formally screened but who exhibit symptoms indicating that they may have a mental disorder (or state that they have such symptoms). For more information about general screening for mental disorders, see Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*.<sup>22</sup> Substance use treatment practitioners who use screening tools for mental disorders should remember that these tools are not for diagnosis.

## What Treatment Is Recommended for OCD?

Behavioral health practitioners who provide treatment for OCD may choose to quantify the severity of OCD symptoms and the related impairment before and during treatment for OCD. There are standardized rating scales for this purpose. The Yale-Brown Obsessive Compulsive Scale is a reliable tool for measuring OCD symptom severity.<sup>23,24,25,26</sup> The client can also be asked to estimate the time spent each day engaging in obsessive-compulsive thoughts or behaviors. It is also important to track the effect of OCD symptoms on relationships, work, self-care, and recreational activities.

The first-line psychosocial therapy recommended for OCD is cognitive-behavioral therapy (CBT), especially

## OCD in Children and Adolescents

Although the average age of onset of OCD in the United States is 19.5 years, 25 percent of cases are diagnosed by age 14.<sup>1</sup> Studies suggest that 40 percent of individuals diagnosed with OCD in childhood or adolescence will experience remission by early adulthood, with appropriate treatment.<sup>1,27,28</sup> OCD in children and adolescents can be treated with CBT<sup>29,30,31</sup> and medication.<sup>29,31</sup>

OCD symptom expression tends to vary between children and adolescents. These differences seem to be related to content that is specific to an individual's stage of development. For example, children are more likely to fear that something bad will happen to themselves or family members.<sup>29</sup> Adolescents are more likely to have obsessions related to religion and sex.<sup>1</sup>

For more information, see:

**The American Academy of Child and Adolescent Psychiatry's *Facts for Families Guide***

[www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/Obsessive-Compulsive-Disorder-In-Children-And-Adolescents-060.aspx](http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Obsessive-Compulsive-Disorder-In-Children-And-Adolescents-060.aspx)

**The International OCD Foundation's OCD in Kids website**

<https://kids.iocdf.org>

a type of CBT called *exposure and ritual prevention* (ERP)<sup>32,33,34</sup> (sometimes called *exposure and response prevention*).<sup>35,36,37,38</sup> ERP involves exposing the client to a dreaded situation, event, or stimulus through the use of various techniques and then preventing the client from performing the compulsive behavior that would usually result upon exposure to such a situation.<sup>21,32,34,37,39</sup>

CBT/ERP can be an effective treatment for OCD, with or without medication.<sup>32,40,41</sup> It is important to note that although some studies on the effectiveness of ERP with medication have excluded individuals with co-occurring SUDs,<sup>33,40,41,42</sup> at least one has not.<sup>34</sup>

A number of studies have explored the use of mindfulness-based interventions in the treatment of OCD,<sup>43,44,45,46,47,48</sup> and clinical trials are in progress.<sup>49,50</sup> However, these are mostly very small studies, suggesting that research in this area is still in its infancy.

Clomipramine (a tricyclic antidepressant) and four selective serotonin reuptake inhibitors (SSRIs; fluoxetine, fluvoxamine, paroxetine, and sertraline) are approved by the Food and Drug Administration for the treatment of OCD.<sup>21,35,36</sup> However, SSRIs are now considered first-line pharmacologic treatments for the disorder. The doses of SSRIs that are required to successfully treat OCD are often higher than the doses required for other conditions. In addition, an individual with OCD may take longer to respond to these medications. For this reason, trial periods are often longer (at least 12 weeks).<sup>51,52</sup> Although all of

**Note:** Prescribed medications can interact with drugs and alcohol—clients taking prescribed medications should be encouraged to be open about their use of substances with their care providers.

the SSRIs listed above seem to be equally effective in the treatment of OCD, an individual patient may respond better to one SSRI than to another.<sup>35</sup>

A number of studies have explored the effectiveness of using adjunctive medications to improve treatment outcomes for individuals who do not respond well to SSRI medication alone. Additional medications being investigated include antipsychotics,<sup>52,53,54,55</sup> *N*-acetylcysteine,<sup>56,57</sup> and memantine.<sup>58,59,60</sup>

Whether a client’s behavioral health problems are being treated with medication, behavioral therapy, or both, it is important for clients and practitioners to shift the focus from primarily illness and disease to wellness and recovery. An approach focusing on wellness and recovery is strengths based and includes interventions to help clients become proactive in managing their overall health and well-being.<sup>61</sup> It focuses on reclaiming important aspects of life that were lost when a mental or substance use disorder began, or on discovering these aspects for the first time. The Substance Abuse and Mental Health Services Administration has identified several essential dimensions of a holistic approach to recovery and wellness (see Exhibit 5).

### Exhibit 5. Dimensions of Recovery and Dimensions of Wellness<sup>62,63,64</sup>

Dimensions of Recovery	Dimensions of Wellness
<b>Health</b>	<ul style="list-style-type: none"> <li>• <i>Physical:</i> Recognizing the need for physical activity, healthy foods, and sleep; managing chronic illnesses</li> <li>• <i>Emotional:</i> Coping effectively with life and creating satisfying relationships</li> </ul>
<b>Home</b>	<ul style="list-style-type: none"> <li>• <i>Environmental:</i> Occupying pleasant, safe, stimulating environments that support well-being</li> <li>• <i>Financial:</i> Obtaining satisfaction with current and future financial situations</li> </ul>
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• <i>Intellectual:</i> Recognizing creative abilities and finding ways to expand knowledge and skills</li> <li>• <i>Occupational:</i> Obtaining personal satisfaction and enrichment from one’s work or daily activity</li> <li>• <i>Spiritual:</i> Expanding one’s sense of purpose and meaning in life</li> </ul>
<b>Community</b>	<ul style="list-style-type: none"> <li>• <i>Social:</i> Building a sense of connection and belonging; building a well-developed support system</li> </ul>



# ADVISORY

OCD is a chronic illness with a high rate of relapse.<sup>21</sup> Patients with OCD may require continued monitoring for the possible recurrence of symptoms or the development of depression and suicidal thoughts.<sup>21</sup> However, remission is possible. Some studies have found that remission from OCD is related to the type and severity of symptoms, the duration of the illness,<sup>65,66</sup> and initial response to medication.<sup>67</sup> One study found that some individuals with OCD were able to discontinue medication without a worsening of symptoms.<sup>68</sup> Like most health care, however, personalized behavioral health care that focuses not only on illness and disease, but also on wellness and recovery, may provide the healing environment most conducive to achieving positive outcomes.

## Resources

### Relevant publications

Treatment Improvement Protocol (TIP) 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*

<http://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992>

*Obsessive-Compulsive Disorder: When Unwanted Thoughts Take Over*

[www.nimh.nih.gov/health/publications/obsessive-compulsive-disorder-when-unwanted-thoughts-take-over](http://www.nimh.nih.gov/health/publications/obsessive-compulsive-disorder-when-unwanted-thoughts-take-over)

*Partners in Health: Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit*

[www.integration.samhsa.gov/operations-administration/IBHP\\_Interagency\\_Collaboration\\_Tool\\_Kit\\_2013.pdf](http://www.integration.samhsa.gov/operations-administration/IBHP_Interagency_Collaboration_Tool_Kit_2013.pdf)

### Web resources

**Anxiety and Depression Association of America** (offers an online screening tool for OCD)

[www.adaa.org/screening-obsessive-compulsive-disorder-ocd](http://www.adaa.org/screening-obsessive-compulsive-disorder-ocd)

### Beyond OCD

[www.beyondocd.org](http://www.beyondocd.org)

**International OCD Foundation** (contains a searchable directory for OCD therapists, clinics, treatment programs, and support groups)

[www.iocdf.org](http://www.iocdf.org)

### National Institute of Mental Health

[www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd](http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd)

### SAMHSA-HRSA Center for Integrated Health

**Solutions** (jointly funded by SAMHSA and the Health Resources and Services Administration [HRSA] and run by the National Council for Behavioral Health)

[www.integration.samhsa.gov](http://www.integration.samhsa.gov)

## Notes

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### *SAMHSA Advisory*

This *Advisory* was written and produced under contract numbers 270-09-0307 and 270-14-0445 by the Knowledge Application Program (KAP), a Joint Venture of JBS International, Inc., and The CDM Group, Inc., for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Christina Currier and Suzanne Wise served as the Contracting Officer's Representatives, and Candi Byrne served as KAP Project Coordinator.

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**Recommended Citation:** Substance Abuse and Mental Health Services Administration. (2016). Obsessive-Compulsive Disorder and Substance Use Disorders. *Advisory*, Volume 15, Issue 3.

**Originating Office:** Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

