

Comorbidities

When OCD exists alongside another condition, it can be difficult to tell where one starts and the other one ends

Words Emma Green

OCD rarely exists within a vacuum. Although it can occur on its own, it is frequently accompanied by other psychiatric and neurodevelopmental conditions, referred to as comorbidities. Also known as co-occurring conditions or dual diagnoses, comorbidities refer to two or more co-existing health problems that can interact, mimic, mask or worsen symptoms in one another - even if one developed

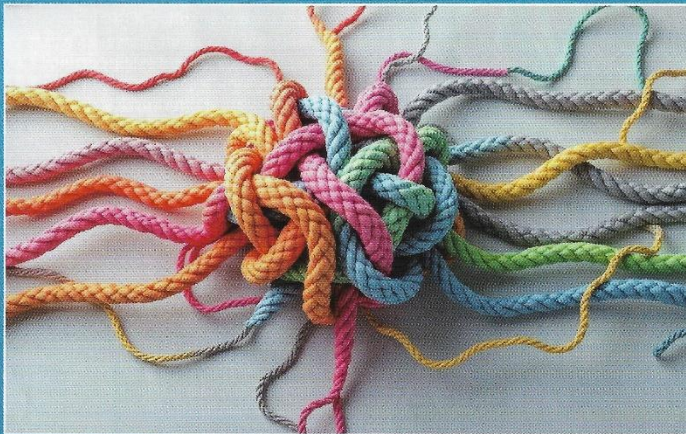
long before the other. It has been estimated that around 90% of those with OCD will experience at least one additional mental health disorder during their lifetime.

"It is important for us to build a full picture regarding whether OCD is the primary condition (the main driver of distress, with compulsions designed to neutralise threat) or the secondary condition (a coping mechanism layered onto another condition)," says Dr Tracy King, a clinical psychologist, trauma

specialist and holistic healer.

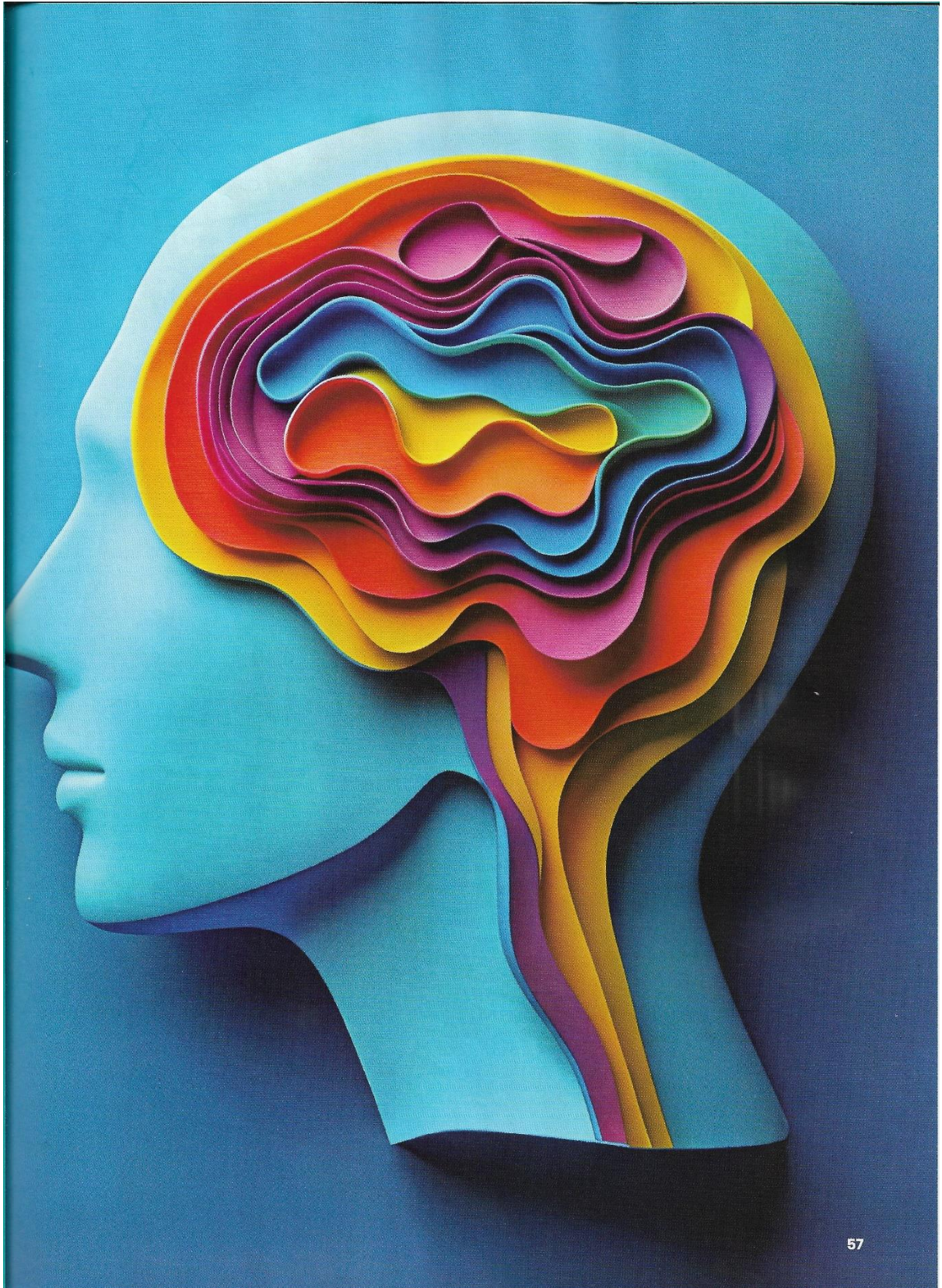
"Sometimes, the relentless cycle of obsessions and compulsions in OCD creates so much stress, exhaustion and disruption that it triggers secondary conditions. Other times, it is functional to an underlying difficulty, a way of regaining a sense of control when life feels overwhelming, chaotic or unsafe. In those cases, OCD operates almost like scaffolding."

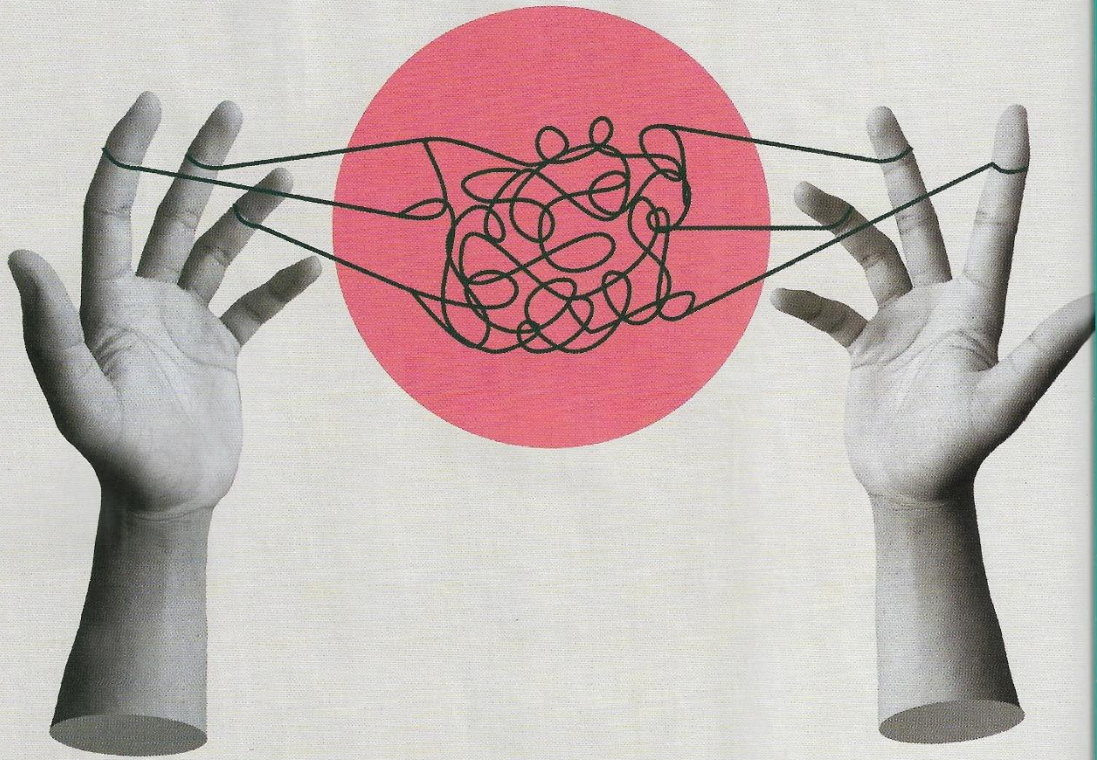
The following is a non-exhaustive list of the most common conditions that can co-occur with OCD.



Mood disorders

Depression is one of the most frequently reported comorbidities in OCD, with estimates suggesting up to 60% of those with OCD will experience a major depressive episode at some point during their lifetime. Depression is more likely to be the secondary condition, often arising after years of untreated OCD. "The endless cycle of intrusive thoughts and compulsions can gradually wear down the nervous system, leading to hopelessness, exhaustion and a sense of failure," says Dr King. "At other times, depression is the primary condition, and OCD





develops on top of it as a coping system, giving the person a sense of structure when motivation and energy are low."

The interaction of both conditions can create a vicious cycle where they reinforce each other in ways that affect mood, cognition and behaviour.

"Depression can be understood as a kind of shutdown," says Dr King. "When the system has been in overdrive for too long, constantly firing with threat signals, it eventually reaches a point of overwhelm. The body protects itself by going into a conservation state, switching off energy and dampening emotions, which shows up as fatigue, emptiness and loss of pleasure. OCD, in contrast, over-activates the brain's error detection and alarm circuits. When the two combine, the person is caught in a painful loop, with little energy to resist compulsions yet feeling constant pressure to perform them."

Anxiety disorders

Not surprisingly, anxiety disorders such as generalised anxiety disorder (GAD) and panic disorder often co-occur with OCD, with their shared features of rumination, hypervigilance and fear of negative outcomes. OCD is classified as an anxiety disorder within some diagnostic frameworks, although the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* - the clinical bible of mental health classification, diagnosis and treatment - now categorises it separately. Still, anxiety is central to the OCD cycle.

"Anxiety and OCD are deeply connected," says Dr King. "In many ways, OCD can be thought of as a specialised form of anxiety, where the nervous system's alarm system is stuck on high alert. OCD takes that heightened state and channels it into particular themes,

such as fears of contamination. Other times, OCD may develop as a coping mechanism, a way of trying to contain the wider, more shapeless worry by ritualising it into something concrete."

Post-traumatic stress disorder (PTSD)

Although PTSD used to be considered a type of anxiety disorder, it is now classified as a 'trauma- and stressor-related disorder', due to its distinct features of flashbacks and dissociation. Nevertheless, anxiety still lies at its core, and PTSD and OCD can interact in complex and overlapping ways when they occur in the same person, with both often involving intrusive thoughts, avoidance, hyperarousal and some compulsive behaviours.

Dr King states that the difference between the two conditions lies in the type of intrusion involved. "In PTSD, the nervous system relives what has already happened," she says. "The person may experience flashbacks, nightmares or body sensations that take them back to the traumatic event. In OCD, the intrusions are 'what if?' scenarios; the mind creates imagined threats that might happen in the future."

Neurodevelopmental disorders

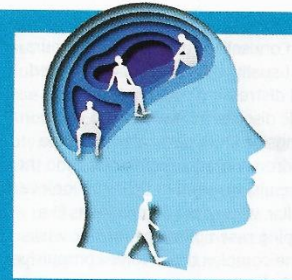
OCD is considered part of the broader neurodivergent family, although it's not classified as a neurodevelopmental disorder. It usually emerges later than classic neurodevelopmental conditions, like autism or ADHD, but shares many features of neurodivergence, including brain differences, atypical cognition and lifelong traits.

"PTSD and OCD interact in complex and overlapping ways when they occur in the same person"



Though seemingly opposite in presentation - OCD being characterised by overcontrol and perfectionism, and ADHD by impulsivity and distractibility - comorbidity between them is common, particularly in children. The co-existence of ADHD and OCD presents unique challenges. ADHD's impulsivity can make it harder to resist compulsions or to follow through with exposure and response prevention therapy (the standard treatment for OCD), while OCD's anxiety can worsen ADHD-related distractibility and executive dysfunction. Both disorders can contribute to difficulties with organising, completing tasks and regulating emotions.

Autistic individuals often show behaviours that resemble OCD, such as repetitive routines and fixated interests. However, their motivations differ: OCD behaviours are performed to relieve anxiety, whereas autistic behaviours often provide comfort, predictability or sensory regulation. Autistic behaviours



Treating OCD alongside other conditions

When OCD coexists with other mental health or neurodevelopmental disorders, treatment becomes more complex.

"Practical barriers can slow progress," says Dr King. "Medications may have different effects across conditions, and what helps one area may worsen another. Therapy itself can be slow, because each condition has its own needs. Hoarding requires in-home work, eating disorders need medical monitoring, and trauma requires grounding and safety before exposure therapy can begin. Another challenge is energy and motivation. OCD is already exhausting; when depression, ADHD or autism is also present, it can feel overwhelming to start therapy."

Clinicians often need to prioritise symptoms, treating the most impairing symptoms first. For example, if OCD and depression co-occur, severe depressive symptoms such as suicidal ideation may take priority before engaging in intensive exposure therapy.

"Knowing whether OCD is the root or branch can help a clinician decide when to treat conditions at the same time, when to prioritise one over the other, and how to avoid collapsing a coping system too quickly," says Dr King. Despite these additional challenges, Dr King says recovery from OCD with a co-existing condition is possible, but highlights the importance of sequencing and flexibility when it comes to treating both.

Comorbidities

are often ego-syntonic (in harmony with oneself), while OCD behaviours are usually ego-dystonic (unwanted and distressing).

Tic disorders frequently co-exist alongside OCD, particularly in male children and adolescents. Tics and the compulsions seen in OCD can look very similar, with some compulsions like tapping resembling the former, while some complex tics involve compulsive-like behaviour, such as repeating phrases or touching objects. The key difference, though, is that OCD compulsions are usually performed to neutralise a fear or prevent harm, while tics are done to relieve an urge or tension.

"When OCD is the primary condition, the compulsion is tied to a specific obsession - for example, touching a surface evenly to stop something bad from happening," says Dr King. "When the tic disorder is primary, the movement or sound comes first, and OCD-like rituals can sometimes grow

around it as a secondary coping strategy to try to control or hide it."

Other obsessive-compulsive spectrum disorders

Obsessive-compulsive and related disorders (OCRDs) was first introduced as a distinct diagnostic category in the *DSM-5* in 2013 to group conditions that share similar features with OCD, particularly in terms of repetitive thoughts and behaviours.

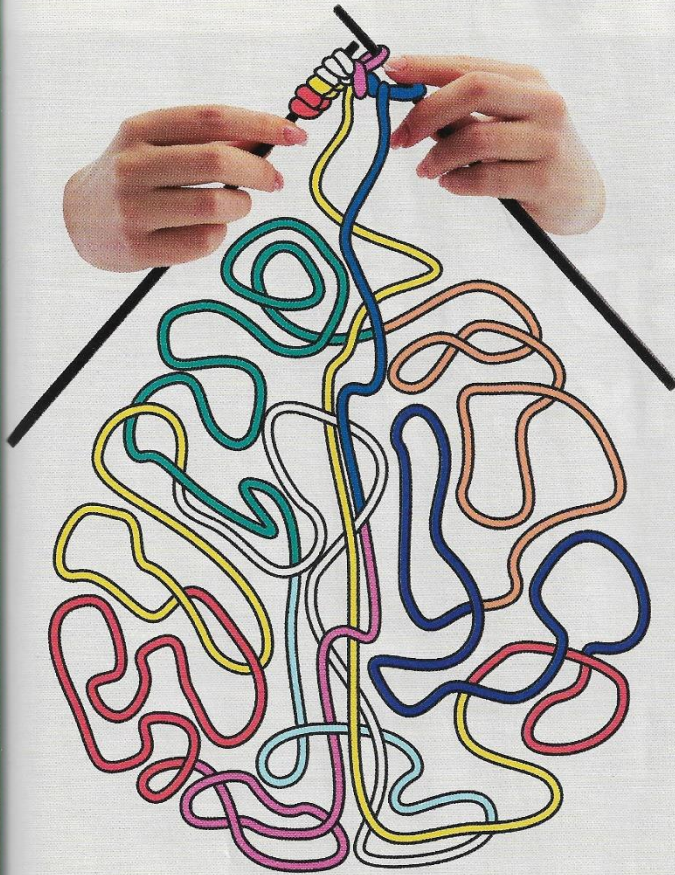
Hoarding was once considered a subtype of OCD but is now recognised as a separate disorder. It is characterised by a difficulty in discarding possessions, leading to cluttered living spaces and functional impairment. Many individuals with OCD can exhibit hoarding behaviours,

particularly when driven by fears of relinquishing something valuable.

"On the surface, hoarding can look similar to OCD, especially when saving items feels tied to anxiety," says Dr King. "But the motivation is usually different. In hoarding, the possessions themselves often feel meaningful or even part of the self. In OCD, compulsive saving is more about preventing harm, such as keeping every scrap of paper in case something terrible happens if it is thrown away."

Body-focused repetitive behaviours (BFRBs) are clinically recognised as part of the OCD-related family of conditions, although only trichotillomania (hair-pulling disorder) and excoriation (skin-picking disorder) are explicitly listed in the *DSM-5* under this category. BFRBs are a group of behaviours where a person repeatedly causes physical damage to their body, often without fully realising it.





“Eating disorders and OCD both involve rigidity, perfectionism and repetitive behaviours”

Sometimes BFRBs can be misinterpreted as OCD, as they both involve repetitive behaviours. However, their motives differ.

“BFRBs aren’t usually driven by a fear of something bad happening,” says Dr King. “Instead, they are more about regulating tension, soothing uncomfortable sensations or responding to a sense of feeling ‘not

right’. In OCD, the cycle is different, as the compulsion reduces anxiety created by an intrusive thought.”

When BFRBs and OCD co-occur, they often interact in complicated and mutually reinforcing ways.

“OCD can sometimes be primary, with rituals creating so much strain that BFRBs develop as a secondary way to manage the overflow of

tension,” explains Dr King. “At other times, OCD-like rituals may grow around BFRBs as a way of making sense of the behaviour.”

Another obsessive-compulsive subtype that often occurs with OCD is body dysmorphic disorder (BDD). BDD involves obsessive preoccupations with perceived flaws in physical appearance, often accompanied by compulsive behaviours such as repeated mirror-checking or seeking reassurance. Individuals with OCD may exhibit BDD-like symptoms, particularly in cases involving checking or grooming compulsions, but BDD is distinct in that the obsessional focus is specifically related to appearance. When they interact, the result can be a deeply distressing and self-reinforcing pattern of overvalued ideation, anxiety and ritualistic behaviours centred around presentation.

Eating disorders

“Eating disorders and OCD often overlap because both involve rigidity, perfectionism and repetitive behaviours,” says Dr King.

These commonalities can include obsessive thoughts and compulsive rituals fixated on eating, such as cutting food into small pieces. “In OCD, compulsions are performed to neutralise a fear – for example, washing hands to avoid contamination,” Dr King says. “In eating disorders, though, the behaviours revolve around controlling weight, shape and food intake.”

OCD can contribute to the development of an eating disorder when obsessions about contamination or health evolve into rigid food rules (for example, only eating ‘safe’ foods) or moral obsessions are projected onto food (‘I’m only good if I eat clean’).

Rituals like body checking, food tracking and obsessive exercise can function like OCD compulsions, aimed at reducing anxiety about weight or shape. When they are experienced concurrently, they often intensify symptoms in one another, increase medical risks and complicate any necessary treatment.

Images: Getty, Adobe Stock