

Obsessive-Compulsive Disorder

A plain-English guide for you and your family

WHAT IS HAPPENING

In a healthy brain, balanced chemical messengers keep your mood steady, your thoughts clear, and your actions smooth. Picture that as normal. Now imagine a specific brain circuit — the one that checks for danger — gets stuck on high alert. It keeps firing the same alarm even when there is no real threat. That flood of alarm creates an obsession: a thought, image, or urge that barges into your mind over and over (germs will kill me, did I lock the door, I might hurt someone). Your thinking brain knows the thought is not true, but the alarm center does not care — it keeps screaming danger. To quiet that unbearable anxiety, you do a compulsion: wash your hands again, check the lock one more time, count to four, repeat a phrase. The ritual works for a few seconds, so your brain learns to rely on it — and now the loop is locked. Biology set the stage, but stress, trauma, and isolation make the circuit stickier. Treatment works by teaching the brain a new path: face the thought without doing the ritual, and over time the alarm learns to quiet on its own. Every symptom makes sense once you see the stuck circuit underneath.

What you might feel

- Unwanted thoughts that come back over and over (obsessions)
- Repeating the same action again and again to feel safe (compulsions)
- Spending one hour or more every day on obsessions or compulsions
- Intense fear or discomfort if you try to stop the ritual
- Avoiding people, places, or things that trigger the obsessions
- Knowing the thoughts or rituals don't make sense, but feeling unable to stop
- Skin damage from excessive washing or other physical rituals
- Thoughts of harming yourself because the condition feels unbearable

Call the doctor right away if...

- Thoughts of suicide or a plan to harm yourself
- Unable to eat, sleep, or go to work or school because of obsessions or compulsions

- Physical injury from compulsions (bleeding skin, severe weight loss from food rituals, fainting from excessive cleaning)
- Sudden worsening after a throat infection in a child (may signal PANDAS, a separate condition needing urgent care)

What the care team will do

- Screen for active suicidal thoughts, self-harm plans, or access to lethal means at every visit, and create a written safety plan if ideation is present
- Assess for physical injuries from compulsions, including checking hands for cracked bleeding skin, weighing the patient for malnutrition, and asking about chemical exposure from cleaning products
- Never reassure the patient their fear is not real or argue with the obsession content, and do not participate in or enable compulsive rituals
- Teach the patient that OCD medication requires higher doses and 10 to 12 weeks at full dose before improvement appears, unlike depression which responds in 4 to 6 weeks
- Educate the patient that Exposure and Response Prevention therapy, not medication alone, produces the strongest and longest-lasting improvement in OCD symptoms
- Monitor for serotonin syndrome (confusion, racing heart, high fever, muscle rigidity, sweating) when combining high-dose SSRIs with clomipramine or other serotonergic drugs
- Ask about new movement problems, restlessness, or weight gain when an atypical antipsychotic is added to the SSRI regimen
- Coordinate referral to an OCD specialist or intensive outpatient program if the patient shows no improvement after 12 weeks of high-dose SSRI plus adequate ERP therapy trials

Medicines you may be given — and why

Fluoxetine (Prozac)

Fluoxetine blocks the pump that sucks serotonin (a brain messenger that steadies mood and worry) back into the nerve cell. When serotonin stays in the gap between nerves longer, it can gradually calm the alarm circuits firing the obsessions and compulsions. OCD needs a much higher dose than depression—usually 60 to 80 mg a day—because the worry circuits are more stubborn.

Sertraline (Zoloft)

Sertraline blocks the serotonin reuptake pump, keeping serotonin in the synapse longer so it can calm the stuck worry circuits. For OCD, the dose is usually pushed to 200 mg a day—

higher than the dose used for depression or general anxiety—because the brain loops driving obsessions and compulsions need a stronger nudge.

Clomipramine (Anafranil)

Clomipramine is an older medicine that blocks the pump for serotonin very powerfully—even more so than most SSRIs—and it has been the gold standard for OCD for decades. It also blocks pumps for norepinephrine (another brain messenger), but the serotonin effect is what quiets obsessions and compulsions. Clomipramine is usually tried when SSRIs do not work well enough.

Aripiprazole (Abilify) - low dose, added to an SSRI

Aripiprazole is NOT an OCD medicine by itself—it is added in a low dose (usually 5 to 15 mg a day) when an SSRI or clomipramine only partly helps. It works as a partial agonist at dopamine D2 receptors and serotonin 5-HT1A receptors, which means it gently nudges these receptors without fully turning them on or off. This fine-tunes the balance between serotonin and dopamine in the OCD circuits, and for some people it pushes symptom relief over the finish line.

Risperidone (Risperdal) - low dose, added to an SSRI

Risperidone is another antipsychotic that can be added in a low dose (usually 0.5 to 3 mg a day) when an SSRI or clomipramine does not fully control OCD. It blocks dopamine D2 receptors and serotonin 5-HT2A receptors, which helps rebalance the circuits in the striatum and prefrontal cortex that drive obsessions and compulsions.

Where this information comes from

- American Psychiatric Association DSM-5-TR
- International OCD Foundation clinical guidelines
- Cochrane Review on CBT and SSRIs for OCD
- APA Practice Guideline for OCD 2007 (updated references 2024)

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