

The Overlap of PTSD and OCD

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People with post-traumatic stress disorder (PTSD) are ten times more likely to develop obsessive-compulsive disorder (OCD; de Silva, 1999). People who have been diagnosed with OCD and have had past exposure to trauma have greater impairment of functioning (Albert & Chen, 2025). The development, progression, and severity of OCD are attributed to childhood trauma. 46.7% of patients diagnosed with OCD were also diagnosed with complex post-traumatic stress disorder (cPTSD; D'Angelo et al., 2024). According to a medical study of morbidity, 5.2% of Vietnam War veterans have OCD. The severity of obsessive-compulsive symptoms (OCS) is greater in youth with comorbid OCD and PTSD (Wislocki et al., 2022). PTSD and OCD influence each other. Numerous case studies show a history of trauma contributing to the development of trauma-related OCD. Research indicates exposure to trauma does not necessarily lead to PTSD (McLean & Brown, 2023). The data serve as a reminder to clinicians to treat symptoms, not traumatic experiences. Evidence suggests in the presence of PTSD and OCD comorbidity; PTSD typically develops first. Symptoms of anxiety and depression are more severe in people who develop OCD after PTSD (Albert & Chen, 2025). PTSD develops events which do not fit the typical definition of trauma. Regardless of their developmental pathways, the two conditions can be comorbid and continue causing significant impairment.

Vulnerability Factors

Vulnerability factors play an integral role in the development of OCD after exposure to extreme stress. The research indicates four specific vulnerability factors: elevated moral standards, including striving for moral perfectionism; cognitive biases, such as thought-action fusion (TAF); an elevated sense of responsibility; and depressed mood and anxiety proneness (de

Silva & Marks, 1999). Obsessional cognitions which occur during the onset of acute stress become increasingly intrusive. Trauma-related OCD refers to the development of trauma-induced obsessions. An elevated and irrational sense of responsibility during traumatic events is a vulnerability factor which plays a part in generating obsessional cognitions and subsequent OCD symptoms. Dysphoric mood following a traumatizing experience leads to the development of obsessions (Medina-Rodríguez & Solís-Villegas, 2022). Several vulnerability factors operate jointly and contribute to OCD.

Intrusive Thoughts

Data positively correlate with the results of the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and the Impact of Event Scale (ITQ), indicating the influence of cPTSD on the development of OCD symptoms (D'Angelo et al., 2024). Flashbacks and nightmares measured by the ITQ are symptoms of PTSD and manifest as intrusive thoughts related to the traumatic event. The symptoms escalate a pattern of fear, anxiety, anger, aggression, and depressive symptoms. Disruption of self-organization leads to the development of obsessive thoughts. The pervasive nature of the symptoms contributes to the chronicity and severity of the obsessions. There are greater rates of sexual obsessive-compulsive symptoms in the research surrounding OCD and PTSD comorbidity.

Repetitive Behaviors

Clinicians observed repetitive behaviors since the establishment of psychoanalysis (O'Connor et al., 2010). Repetition is an emergence of the unconscious into the conscious. Repetition is common to OCD and PTSD. OCD is not a post-traumatic condition, but obsessive thoughts develop in the same way as the re-experiencing symptoms (flashbacks and nightmares) in PTSD. The etiology of obsessional thought reflects an experience which elicits a similar sense

of dread. Obsessional thoughts focus on future negative outcomes (Pinciotti, 2025). Obsessional thoughts represent a chain of meaningful events which hold some particular concern. The circular movements intrinsic to obsessional thoughts are a symptom of the unconscious search for a missing link in an experience (O'Connor et al., 2010). The subsequent compulsions intend to blunt the anxiety induced by an obsessional thought, creating a cycle of obsessions and compulsions. Post-traumatic stress-induced dreams are repetitive and contain concerns which have yet to be adequately addressed. Cognitive cycles which narrow the internal experience explain the way compulsive behaviors develop to reduce anxiety, but do not eliminate the obsessions which cause it. The cognitive cycles are not reduced until the obsessional thoughts are processed effectively, a pattern like PTSD.

Avoidant Compulsions

Avoidant behaviors are common in OCD and PTSD. Avoidance manifests in voluntary and involuntary dissociative symptoms in response to emotional dysregulation. Dysregulation is an impaired state characterized by an unbearable internal experience, including emotions, thoughts, body sensations, and physiological arousal (D'Angelo et al., 2024). A perceived or real threat activates emotional dysregulation. Obsessive thoughts are experienced as threatening and lead to an acute stress response. Compulsions are maladaptive behaviors which prevent new information from contributing to the processing needed to reduce obsessive thoughts. The repetition of traumatic childhood experiences, which lead to cPTSD, influences the dissociative nature of compulsions. Dissociation and related symptoms reported in childhood reinforce rigid personality traits, factors in the severity of OCD (Semiz et al., 2014). Maladaptive dissociative symptoms decrease an individual's resilience and ability to recover from additional stressful events. Compulsions are traced back to earlier formative years, before the development of the

obsessions. Compulsions can be attributed to symptoms of cPTSD (Albert & Chen, 2025). In addition to the symptoms of classic PTSD, cPTSD includes emotional dysregulation, negative self-concepts, and relationship disturbances. The symptoms are the result of increased responses to pervasive stress in the environment, which become maladaptive due to the repetition of trauma exposure.

Effective Treatment

Treatment for OCD, whether trauma-related or non-trauma-related, focuses on educating clients in the process of approaching and tolerating distress while preventing compulsions (McLean & Brown, 2023). Exposure therapists are trained to help clients achieve generalization. There are three treatment plans which evidence shows are effective for the comorbidity of OCD and PTSD: sequential, concurrent, and integrated treatment. Trauma-related OCD is a subtype of OCD, indicating it will require adjustments to the treatment used for conventional OCD (Gershuny et al., 2008). Before each treatment, exposure therapists assess for feared outcomes. Feared outcomes are maladaptive predictions which fall into one of four categories: the likelihood of an aversive event, the length of distress, the consequences of activating distress (e.g., loss of control, etc.), and other people's reactions. Sequential treatment includes addressing feared outcomes and the underlying symptoms related to traumatic experiences, which is essential in reducing the severity of OCSs. Feared outcomes are present in OCD and PTSD, leading to distress which activates compulsions or dissociation. Dissociative symptoms predict poor treatment outcomes (Semiz et al., 2014). Exposure therapies including Exposure and Response Prevention (ExRP), Prolonged Exposure (PE), and eye movement desensitization and reprocessing (EMDR) aid in processing feared outcomes and traumatic memories which contribute to both maladaptive dissociation and the development of obsessive thoughts. Exposure

therapies test the maladaptive hypothesis of feared outcomes in real time, helping clients increase tolerance of distress and uncertainty. The processing of trauma memories is essential for symptom reduction. Concurrent treatment includes mindfulness-based treatment, which allows clients to develop a non-judgmental awareness of emotions, thoughts, and body sensations, leading to increased tolerance of distressing stimuli and reduced vulnerability factors that contribute to obsessive thoughts. Integrated treatment includes medication management that reduces the intensity of symptoms while psychotherapy is being administered. There is insufficient research on the treatment interventions to provide guidance on choosing between the three modalities (McLean & Brown, 2023).

Conclusion

It is important to recognize the profound impact trauma has on the severity of OCSs. It is difficult to treat OCD and PTSD when they are comorbid. Research indicates both disorders have multiple etiological factors, suggesting the need for clinical competence in both diagnoses to ensure clinicians use effective interventions when comorbidity occurs (Medina-Rodríguez & Solís-Villegas, 2022). Despite the research needed to develop more evidence-based treatment options for trauma-related OCD, exposure therapies are effective if they are used in collaboration with the client, which allows the individual to live a life worth living (Pinciotti, 2025). Whether addressing feared outcomes, traumatic experiences across the lifespan, or generalization of coping skills, clients desire symptom reduction and improved relational stability when PTSD and OCD are comorbid. The goals of exposure therapies are to reduce symptom intensity regardless of diagnosis.

More research is needed to explore the functional connection between the symptoms of both PTSD and OCD. There are quantitative studies on the comorbidity of OCD and PTSD, but

more longitudinal and qualitative studies would illuminate the relationship between the two disorders. Quantitative studies use instruments to measure symptoms, making it challenging to collect aggregate data. More research will expedite the discovery of ways to alter exposures for more efficient, effective outcomes.

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