

# Obsessive compulsive disorder research papers examples

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Like the old saying goes, “ Cleanliness is next to godliness,” but at what point does cleaning and being tidy cross the line into mental illness?

Likewise, while a large percentage of the population may admit to being a little superstitious and many hotels don’t include a 13th floor, at what point does certain superstitious beliefs and behaviors turn into compulsions or behaviors that must be carried out or else the individual is unable to proceed throughout his or her day? To an outsider, it may appear like a nonsense disease with behaviors that should be easy to curtail by just stopping the actions; however, to the individual who is suffering from the compulsion to carry out the actions it can be life consuming, altering every aspect of his or her life. It is important to understand the symptoms and what it feels like for the person who is experiencing the compulsions, possible contributing factors to the development and maintenance of the behaviors, as well as society’s view and treatment options.

## **What is Obsessive Compulsive Disorder?**

Double checking the door to make sure it is locked, ensuring the stove is turned off before leaving the house, hand washing, or even doing the dishes before going to bed; these are all actions that many individuals carry out on a regular basis, often without thinking about it. However, individuals with obsessive compulsive disorder (OCD) feel the obligation to check items repeatedly, and if the ritual is not carried out exactly as required, distress may occur. The actions and behaviors that are carried out by the individual with OCD are often accompanied by frequent upsetting thoughts, which are called obsessions. The ritual behaviors are often employed as a way to control the obsessions; both of which are unable to be controlled by the

individual, leading the rituals to control the life of the individual. Performing the rituals often does not bring a sense of pleasure, but rather produces a temporary sense of physical and emotional relief from the anxiety that is brought on by the obsessive and intrusive thoughts.

Some common rituals include the need to repeatedly check things, touch things in a particular sequence, or count things such as steps, items of food, or other objects. According to the National Institute of Mental Health (2014), some frequent obsessions include “ having frequent thoughts of violence and harming loved ones, persistently thinking about performing sexual acts the person dislikes, or having thoughts that are prohibited by religious beliefs.” Other examples of obsessions include germs, images of violent scenes, thoughts of carrying out violent crimes such as kicking a baby or shooting a stranger, fear of causing harm to oneself or others (either accidentally or intentionally), the fear of losing an item or possession, and superstitions (Bokor & Anderson, 2014). The most common obsession associated with OCD surrounds the fear of contamination (Menchon, 2012). Additionally, individuals with OCD may experience a preoccupation with both order and symmetry of objects and may hoard unneeded items due to a difficulty in throwing things out. Some of the compulsions or physical actions that are commonly seen in individuals with OCD include the excessive washing of hands, extreme preoccupation with cleaning household items, a need to wash one’s body in a particular order when bathing, and either rereading or rewriting the same material over and over (Bokor & Anderson, 2014). Recent research suggests that the most common compulsions performed by individuals with OCD is of the checking nature, followed by washing or

cleaning (Menchon, 2012).

The newest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes a whole chapter devoted to obsessive compulsive and related disorders to reflect the increasing prevalence of similar disorders including hoarding, body dysmorphic disorder, trichotillomania (hair pulling disorder), and excoriation (skin picking) disorder (American Psychiatric Association, 2013). According to the DSM-5, there are three general criteria that must be met in order for an individual to receive a diagnosis of OCD:

- Both obsessions and compulsions must be present;
- The life of the individual must be significantly impacted by the obsessions and compulsions; and
- The recognition by the individual of the excessive nature of the compulsions and obsessions is not necessary.

**Also, according to the DSM-5, the following obsession criteria must be met:**

- Distress is experienced as a result of the persistent, repetitive, and often intrusive thoughts or urges;
- The obsessive thoughts or urges do not focus on the problems that currently exist in the life of the individual, but rather focus on the compulsions;
- Attempts at suppressing or ignoring the obsessive thoughts have been unsuccessful; and
- The individual doesn't necessarily have to acknowledge that the thoughts are generated from his or her mind and that the thoughts are not an actual threat.

**The other aspect of OCD, the compulsions, the following criteria must be met:**

- The behavior that is excessive, repetitive, and ritualistic in nature is carried out due to the fear of bad things happening if the behavior is not completed in a specific way;
- At least one hour per day is devoted to carrying out the behavior or ritualistic compulsions; and
- In an attempt at quelling the anxiety contributed by the obsessive thoughts or images, the physical behaviors or mental acts (counting and other silent mental rituals) are carried out, often yielding only temporary relief, if any at all.

Figure 1. Model of OCD

**Prevalence of OCD in the United States**

While the degree of which the symptoms may vary, from consuming an hour or so a day, to completely debilitating, recent research into OCD has revealed that the number of people who experience symptoms of OCD rivals that of those who experience symptoms of asthma worldwide (Menchon, 2012). It is estimated that more than 25 percent of individuals may experience some sort of preoccupation with obsessions and/or compulsions at some point in time during their lives, with many of those meeting the criteria for OCD (Menchon, 2012). Additionally, the lifetime prevalence of OCD ranging between two and three percent among the general population (Menchon, 2012), but has also been estimated to affect up to four percent of the population, and may be higher in individuals who have had cosmetic surgery (Greenberg, 2013). Within the United States, over two million adults

experience some type of OCD to some degree, with most individuals been diagnosed by the time they have reached adulthood; although one-third of adults who experience symptoms of OCD developed symptoms as a child (NIH, 2014), or 1 in 100 children (Ayuso-Mateos, 2001).

With the recent expansion of the definition and diagnostic criteria of OCD located in the newer version of the DSM-5, the number of individuals who meet the criterion for OCD is expected to increase. In 2000, OCD was found to be one of the “ top 20 causes of illness-related disability, worldwide, for individuals between 15 and 44 years of age” (Ayuso-Mateos, 2001). Half of those diagnosed with OCD has symptoms that are classified as “ severe,” thus impeding on the quality of life of the individual (Kessler, Chiu, Demler, & Walters, 2005). As the definition of OCD is expanded to include a variety of subtypes, the prevalence of OCD is expected to increase. Some of the proposed subtypes include pedopsychiatric OCD (early onset OCD), children who have OCD symptoms in conjunction with pediatric autoimmune neuropsychiatric disorder (PANDAS), and tic-related OCD that occurs with Tourette’s syndrome (Thomsen, 2013).

## **Prevalence of OCD Among Different Groups**

Often mental illnesses do not affect the population equally, with certain factors increasing the likelihood of an individual developing a certain disease. In the case of OCD, it often occurs with other mental health issues and researchers have found that there may be a higher prevalence of developing OCD depending on geographic region, ethnicity, and even

religious affiliation. Additionally, gender may play a role in the development of OCD symptoms.

## **Co-occurring Disorders and OCD**

Research has also indicated that OCD is often present in eating disorders, with the relationship dating back decades and was first documented in scientific research in the 1930s and was associated with the personality traits of “compulsion neurosis” and “compulsive obsessive” (Pollack & Forbush, 2013). Researchers hypothesize that the relationship may be due to the preoccupation and obsessive thoughts that surround contamination and cleaning; individuals with comorbid OCD and eating disorders also score high in certain personality traits, particularly neuroticism and perfectionism (Pollack & Forbush, 2013). Behaviors such as continually checking one’s body measurements, frequent weighing, and either recurrent checking of one’s body in the mirror or shunning mirrors completely are also common behaviors individuals with eating disorder can often engage in, which also mimic traditional actions performed by individuals with OCD (Pollack & Forbush, 2013). While the presence of an eating disorder does not necessarily guarantee that OCD will also be present, but research suggests that nearly one-fifth of individuals with eating disorders also has OCD, with more individuals diagnosed with bulimia nervosa having comorbidity of both disorders when compared to those diagnosed with anorexia nervosa (Altman & Shankman, 2009).

## **Gender and OCD**

Among the various anxiety-related disorders, OCD appears to be one of the few disorders that is “equal opportunity” in that OCD affects both males and females nearly equally. However, the difference becomes clear when examining the spectrum of disorders that fall under the umbrella term of OCD, which due to the changes within the new DSM lumps OCD into one chapter of disorders which may artificially equalize the rate of occurrence among the genders. Research suggests that trichotillomania and hypochondriasis are more common among women than men, while men are more apt to develop Tourette’s disorder when compared to women (Lochner & Stein, 2001). Women who experience symptoms of OCD also have higher rates of depression and eating disorders, while men with OCD have higher rates of social phobia, tic disorders, hypomania, and alcohol dependence (Cherian et al., 2014). As for the way OCD symptoms are expressed, women are more prone to experience more aggressive obsessions and cleaning rituals, while men are more likely to report more sexual obsessions and obsessions associated with symmetry and exactness, as well as perform rituals that are odd in appearance (Antony, Downie, & Swinson, 2001).

## **Culture and OCD**

The term culture encompasses a wide variety of variables, from ethnicity and religion, to the education and income status of an individual. Additionally, culture consists of the factors that influence one’s behavior, such as geographic location. Research suggests that an OCD diagnosis occurs more frequently among white, which consists of over 80 percent of the cases

reported; the remaining 20 percent is comprised of Hispanic, Asian, black, and “ other” (Antony, Downie, & Swinson, 2001). However, the prevalence of OCD among Caucasian individuals may not be an accurate representation, as other cultural factors may influence the reporting of OCD cases. Some of the variables that may skew the results include the religious preference and income or educational level achieved. According to research, individuals who identify as being religious also report both higher rates and greater severity of symptoms present, with most identifying as either Roman Catholic or Protestant (Antony, Downie, & Swinson, 2001).

There doesn't appear to be a difference in the rate of OCD on a global scale, however, when compared to the United States, Canada, Puerto Rico, Munich, Korea, and New Zealand, individuals residing in Taiwan reported OCD symptoms at a rate that is less than half of their counterparts (Antony, Downie, & Swinson, 2001). Within the United States, there appears to be a slight difference between rural and urban geographic locations, with younger (between 18 and 24 years) individuals residing in urban locations reporting significantly higher rates of OCD when compared to those who live in a more rural setting; however the differences between urban and rural locations disappeared as the age increased (Antony, Downie, & Swinson, 2001). In regards to ethnic background, African Americans residing in a rural setting were more likely to report symptoms of OCD than those living in urban settings; Caucasians did not seem to be affected by geographic location (Antony, Downie, & Swinson, 2001).

Educational background also appears to be a contributing factor to the development of OCD symptoms, with the amount of education achieved

being negatively associated with the experience of OCD. Among OCD individuals who participated in an anxiety clinical trial, 90 percent of participants had graduated from high school, 53 percent had completed an undergraduate degree or attended technical school, and 10 percent of OCD patients had completed a graduate degree (Antony, Downie, & Swinson, 2001). The educational background may also account for the higher rates of OCD symptoms among those who are either unemployed, underemployed, or receiving welfare or family support (Antony, Downie, & Swinson, 2001).

## **How is OCD Viewed by Society?**

Many mental illnesses have a stigma attached to them, which society applies to both the illness and the individuals who either have the disorder or are actively seeking assistance for their symptoms. Unfortunately, OCD is not immune to such negative views. Many in society view the obsessions and compulsions that are the hallmark of OCD as a result of being weak-willed and having a lack of self control (Stein, 2012). Those who are not familiar with the specifics of the disease (and mental illness as a whole) often view OCD symptoms as easy to fix; all the person suffering from the symptoms of OCD need is a physician to tell them to stop the behavior (Stein, 2012). However, it is not that easy, as the behaviors and actions associated with OCD are deeply ingrained through conditioning or through brain damage.

## **Treatment Options for OCD**

Research into effective treatments to relieve the obsessions and compulsions that are associated with OCD have revealed several promising options. Both pharmacological and psychotherapeutic interventions are

available, providing relief from the symptoms that plague those with OCD.

One of the most effective methods among the pharmacological option is the use of selective serotonin reuptake inhibitor (SSRI), which has been shown to provide relief in up to 60 percent of individuals with OCD; however the benefit gained is only considered to be moderate (Durand & Barlow, 2010).

Cases of severe treatment-resistant OCD has been shown to benefit from the use of intravenously administered clomipramine, a tricyclic antidepressant (Feusner & Bystritsky, 2005).

Treatment options other than those that involve pharmacological intervention include a variety of psychotherapies, one of which is behavioral therapy, which has been shown to be quite effective in reducing the symptoms of OCD. Behavior therapy views human nature and thus the symptoms of OCD in a scientific view, holding that human behaviors are the result of both the individual and his or her environment (Corey, 1986).

According to Corey (1986), there are five specific characteristics that are present in behavior therapy:

- The focus is on the current influences of behavior, rather than attributing the behavior to historical events.
- Overt behavior change is the primary goal or objective of treatment.
- The goals of treatment are concrete and objective, thus allowing for measuring the achievement.
- Treatment is based around the scientific method.
- Problems are identified and targeted during therapy, with progress towards the goals measured throughout the counseling treatment sessions.

In regards to OCD, there are two popular behavior therapy techniques that

have been shown to be quite effective. Both systematic desensitization and flooding have been shown to decrease the severity of the symptoms experienced. Systematic desensitization involves a gradual exposure to the stimuli which has been known to elicit an anxiety response. In order to refrain from utilizing the previously ineffective coping techniques, clients are instructed in relaxation techniques that they can implement when experiencing the anxiety trigger. Similar to systematic desensitization, flooding involves the client confronting the anxiety-producing trigger stimulus, however, the exposure consists of requiring the client to face the most anxiety-provoking situation all at once, rather than slowly building up to it as in the systematic method (Hooper & Grohl, 2013).

## **Conclusion**

Mental illnesses, such as OCD are pervasive, touching every part of the individual's life. The symptoms of OCD can range from mild to quite severe, leading to complete disruption and preoccupation of thoughts. The newest diagnostic tool may increase the prevalence of OCD cases, as OCD and OCD-related disorders are now under the main heading of OCD, which may help to increase both the visibility and research into the causes and treatment options for the disorder. OCD doesn't appear to discriminate when it comes to gender, however, there is a slight difference when it comes to educational level, geographic location, and religious affiliation. Treatment options for OCD have evolved over time, primarily fueled by an increase in research which helps researchers to understand the underlying causes of both OCD and the various disorders that often accompany the presence of OCD. New

treatment options are on the horizon, but until then, by addressing the behavior and beliefs through behavior therapy, the symptoms of OCD can be managed for a large percentage of the population affected by the obsessions and compulsions associated with OCD.

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