

# Overcoming the OCD Myth

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Many people have misconceptions about Obsessive-Compulsive Disorder (OCD). People often believe that someone has OCD if the person is extremely organized and keeps everything that surrounds him or her clean; however, OCD is much more than that. Understanding what OCD truly is helps prevent people from classifying someone as having OCD when they more than likely do not. Informing people of the correct definition of OCD will help decrease myths about the disorder, such as the myth that people with OCD are “neat freaks.”

OCD means that a person has obsessions and/or compulsions on a daily basis. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* defines obsessions as intrusive and unwanted thoughts, urges, or images; a person must try “to ignore or suppress such thoughts, urges, or images, or to neutralize them with another thought or action” (American Psychiatric Association). The thoughts or actions that a person uses to neutralize their obsessions are compulsions. Compulsions are the repetition of a behavior or mental act that someone feels they must complete in order to satisfy their obsessions. People engage in compulsions hoping to prevent or reduce feelings of distress or to prevent an unwanted scenario; however, the compulsions either are clearly excessive or else have no realistic connection to preventing a certain scenario or emotion. People with OCD experience obsessions and/or compulsions so intensely that it prevents them from engaging in daily activities.

Many people have thoughts and complete actions that resemble OCD; however, in order for a person to have OCD, his or her symptoms must meet the criteria for the disorder. According to the *DSM-5*, a person must identify with four diagnostic criteria in order to be clinically diagnosed with OCD:

- (a) The patient experiences obsessions and/or compulsions daily,
- (b) the obsessions and/or compulsions occupy at least one hour a day, cause distress, or interfere with important areas of functioning (e.g., social or occupational),
- (c) the symptoms are not effects of a substance (e.g., medication or drugs) or a different medical condition, and

- (d) the symptoms cannot be better explained by a different mental disorder (e.g., hoarding disorder or generalized anxiety disorder).

The diagnostic criteria for OCD provide guidelines to help correctly identify people who have OCD.

There are many scenarios where “normal” people engage in thoughts and actions that someone with OCD engages in. For example, when leaving for work, people sometimes worry about whether or not they have locked their house. Someone without OCD will more than likely check the lock once and then leave the house. Someone with OCD will more than likely check the lock many times. The person will continue checking the lock until his or her mind is at ease that it is okay to leave; this process can take a short or long amount of time. If the process takes a long amount of time, then there is a possibility that the person will be late for work and get fired. In severe cases of OCD, the person might become so anxious and/or afraid that he or she decides not to leave the house for the rest of the day. Being late for work or not showing up for work due to OCD displays how the disorder can interfere with a person’s daily life.

The cause of OCD remains unknown, due to a lack of scientific understanding; however, researchers continuously search for causes of the mental disorder (Gavin). Previous studies about OCD lead researchers to believe that two main influencers of OCD are genetics (genes) and biology (functioning of the brain) (Mayo Clinic Staff).

Researchers have conducted studies with various families that have many members with OCD. Each study shows a pattern where “people with first-degree relatives (such as a parent, sibling, or child) who have OCD are at a higher risk for developing OCD themselves” (“Obsessive-Compulsive Disorder”). Studies also show that when several family members have OCD, they often engage in the same type of compulsions (repetitive checking, counting, hand washing, etc.) (Hollander 142). After conducting studies on genetics and OCD for seventy-five years, researchers have concluded that there is a strong connection between the two (Hollander 142-143).

Researchers at Michigan Medicine recently conducted a study and concluded that the brain of someone with OCD operates differently than the brain of someone without OCD.

Luke Norman, lead author of the Michigan Medicine study on OCD and a postdoctoral researcher in the Psychiatry Department at the University of Michigan, states that when people have OCD, their “brain responds too much to errors, and too little to stop signals” (Gavin). Kate Fitzgerald, Co-Director of the Pediatric Anxiety Disorders Program at Michigan Medicine and a psychiatry faculty member at the University of Michigan, elaborates on Norman’s conclusion by stating, “This analysis sets the stage for therapy targets in OCD, because it shows that error processing and inhibitory control are both important processes that are altered in people with the condition” (Gavin). Overall, the study displays that people with OCD know that they do not have to act on their obsessive thoughts in order to prevent a certain scenario; however, that idea does not reach the part of the brain that helps them refrain from engaging in obsessions, which explains why people often engage in obsessions.

People with OCD experience various symptoms, such as the need to repetitively tap, organize, or clean. Each physical symptom of OCD leads to a set of psychological symptoms that a majority of people with OCD experience: anxiety, fear, and depression. Anxiety is constantly worrying or fearing everyday scenarios. Fear is being afraid of certain things, such as a scenario ending badly. Depression is constantly feeling sad and having no interest in everyday life. All three of these symptoms have a major role in OCD.

The majority of OCD symptoms are driven by anxiety and/or fear and also produce anxiety or fear. Renee Fabian lives with OCD every day; her experience with OCD displays how fear and anxiety have a major role in the disorder. Fabian’s OCD began with a nightly ritual. “It starts with a prayer, listing my mom, dad, brother, grandparents, cats, rabbit, all my family, and asking for them to be safe. I repeat this list over and over until it feels ‘just right,’” states Fabian. Next, “I ask forgiveness for my sins and ask for help to be a better person, repeating the phrase in a manic hushed voice in my head until it’s ‘right.” (Fabian). Then, Fabian recites the Lord’s Prayer. “I have to say it at least two times in a row exactly perfect, but I can never say it a total of three times, ever. So if I mess up the first one, I have to say it twice in a row perfectly again, but that’s a total of three attempts, which isn’t allowed, so I have to say it also a fourth time, but I always have to say two exactly in a row perfectly” (Fabian). Then Fabian explains that if she does not recite the prayer perfectly, then she will be punished by her parents, grandparents, or pets passing away. Fabian’s obsession with her nightly ritual causes her to be anxious (anxiety) and afraid (fear) that the universe will punish her if she does not complete it; these feelings lead her to act on her compulsions by completing her ritual perfectly every night. Fear and anxiety enhance OCD because people often struggle to overcome those emotions. When people feel that something bad will happen if they do not engage in a certain action, then they more than likely will engage in it.

There are two main ways that OCD can contribute to a person developing depression. First, OCD often causes people to feel as if they have no control over their mind or body. People can become depressed when they constantly experience uncontrollable and unwanted thoughts that cause them to feel obligated to engage in certain actions. Johnathon Abramowitz, a clinical psychologist and professor in the Department of Psychology and Neuroscience at the University of North Carolina, argues that it is easy for someone with OCD to develop depression because that person’s “life consists of unwanted thoughts and urges to engage in senseless and excessive behaviors.” Second, OCD can cause depression through interfering with someone’s daily life. Abramowitz states that “OCD can be devastating to interpersonal relationships, leisure activities, school or work functioning, and to general life satisfaction.” When OCD causes a person to stop engaging in daily activities, that person could lose their job, friends, spouse, and other things. People with OCD often lose the things that make them happy and mean the most to them, which increases their chance of developing depression.

Since OCD is a complex disorder that is difficult to understand, researchers struggle to find effective treatments for it; however, many medical professionals currently use medication and behavioral therapy when attempting to treat OCD (“Obsessive-Compulsive Disorder”).

Medical professionals often prescribe a selective serotonin reuptake inhibitor (SSRIs) to patients who suffer from OCD (“Obsessive-Compulsive Disorder”). Serotonin is a chemical inside the brain that produces feelings of happiness. SSRIs provide people with more serotonin, which increases their level of happiness and helps treat OCD. Researchers have studied how various doses of SSRIs impact the improvement of OCD. In one study, researchers found that some people respond to small doses (200mg) of SSRIs, but some do not. In the study, those who did not respond to small doses were given higher doses (between 250mg and 400mg), which “resulted in significantly greater and more rapid improvement in OCD symptoms” (Zohar 42). When a person does not respond to SSRIs, some medical professionals will prescribe “antipsychotic medications”; however, “research on the effectiveness of antipsychotics to treat OCD is mixed” (“Obsessive-Compulsive Disorder”). As seen throughout many studies, SSRIs are the most effective medication that researchers have found to help treat OCD, which is why the majority of medical professionals prescribe SSRIs before trying other medications (such as antipsychotics).

Medical professionals, such as therapists, also use behavioral therapy to help treat OCD. The type of behavioral therapy that a therapist often uses is exposure and response prevention therapy (ERP). In ERP, clients are exposed to something that causes them anxiety or fear in hopes to reverse their feelings toward the subject. A therapist often uses ERP to help clients overcome OCD by having them come face-to-face

with a situation that usually causes them to engage in a compulsion. Then the therapist will help each client refrain from engaging in the compulsion. For example, when a client feels that he or she must wash his or her hands after interacting with other people, the therapist will have the client interact with others and then help the client refrain from washing his or her hands.

While many therapists use ERP, each therapist has his or her own approach to it. For example, some therapists practice ERP with a client in their office, some practice with a client outside of their office, and some ask a client to practice without them entirely (Davidson 96). “Yet in all cases, the goal is the same: facing obsessions and tolerating discomfort without engaging in compulsions so you can change your expectations about the consequences of facing your fears,” states Joan Davidson, licensed psychologist and Co-Director of the San Francisco Bay Area Center for Cognitive Therapy (96).

OCD is a serious disorder that deserves to be understood correctly. In 2013, the *DSM-5* gave OCD its own section in the diagnostic manual, which acknowledges OCD as its own mental disorder. (It had been previously categorized as an anxiety disorder.) Establishing OCD as its own mental disorder allows more opportunities for people to become aware of the disorder, better understand it, and possibly influence researchers to conduct more research on it. As of now, OCD is not a well-established mental disorder; however, researchers and medical professionals continue working hard to better understand it. Hopefully, discovering and spreading more information about OCD will help the “neat freak” myth disappear.

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