

Research Paper

Digital Rituals: A Compulsion Migration Model of Obsessive-Compulsive Disorder in the Smartphone Era

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ABSTRACT

Most of what we know about obsessive-compulsive disorder was built around rituals that happen in physical space: a lock checked, hands washed, objects nudged into place until they feel right. Over the last decade, though, a scattered body of research has been describing something that looks a lot like the same disorder showing up on a screen instead, people searching the internet over and over for reassurance about a feared illness, saving thousands of photos they cannot bring themselves to delete, or picking up their phone every few minutes to make sure nothing has gone wrong. Cyberchondria, digital hoarding, and habitual phone-checking have each been studied in their own corner of the literature, but nobody has really asked why compulsive behaviour keeps drifting toward digital tools, or what keeps it there once it has arrived. This paper takes on that question. Drawing on the cognitive-behavioural theory of obsessions (Salkovskis, 1985; Rachman, 2002) and on habit theory (Wood & Neal, 2007), it puts forward what I am calling the Compulsion Migration Model. The basic argument is that digital environments are not just a new place for old compulsions to happen; they actively make those compulsions stronger, through three features that physical settings rarely have to the same degree: almost no effort required, information that never quite settles the doubt, and reward that arrives unpredictably. A further claim, and probably the more original one, is that digital rituals tend to pile on top of physical ones rather than replace them, so a person's total compulsive load can grow even while their visible, physical symptoms appear to improve. The paper works through each of the classical OCD symptom dimensions and asks what a digital version would look like, places the model alongside broader theories of problematic internet use, and considers why it might matter especially in Indian clinical settings, where smartphone adoption has happened so quickly. It ends by asking what clinicians assessing and treating OCD might need to change, and what would need to be tested before any of this could be taken as more than a plausible story.

Keywords: *Obsessive-Compulsive Disorder, Digital Compulsions, Cyberchondria, Digital Hoarding, Habit Formation, Cognitive-Behavioural Model, Exposure and Response Prevention*

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Obsessive-compulsive disorder (OCD) is usually described as intrusive, unwanted thoughts paired with the repetitive behaviour a person performs to bring the resulting distress back down (American Psychiatric Association, 2022). Nearly every model built to explain how compulsions work, going back to the earliest behavioural accounts, had a physical ritual in mind: a hand washed, a stove checked, an object lined up just so. That assumption made sense when these models were being built. It is starting to make a lot less sense now.

A large part of daily life has moved onto a phone, and it looks like compulsive behaviour has followed it there. Someone who might once have gone back to check a locked door now opens a home-security app instead. Someone who might once have asked a family member, again, whether a symptom sounded serious now types it into a search engine, sometimes many times in a single day. People who used to hold on to physical belongings they could not bear to throw out now do the same thing with photos, screenshots, and files, at a scale no house could physically contain (Sweeten, Sillence, & Neave, 2018; van Bennekom, Blom, Vulink, & Denys, 2015). None of this is a small or abstract shift: India alone passed 800 million internet users in early 2025, and for most of them a mobile phone is not just the main way online, it is the only way (DataReportal, 2025).

Each of these digital patterns has been written about separately. Cyberchondria has its own literature within health anxiety and OCD research (Starcevic & Berle, 2013; Starcevic, Berle, & Arnáez, 2020); digital hoarding shows up in a handful of case reports and surveys (van Bennekom et al., 2015; Sweeten et al., 2018); habitual phone-checking has mostly been studied by human-computer interaction researchers rather than clinicians (Oulasvirta, Rattenbury, Ma, & Raita, 2012). What none of this literature does is explain why these three things are connected, why compulsive behaviour, given the choice, seems to gravitate toward digital tools, and why, once it gets there, it tends to stay.

This paper tries to offer that explanation. Everything in it is built from existing theory and existing findings; there is no new data here. What it contributes is a way of reading several separate literatures together. The core claim is simple: digital environments are not a neutral backdrop that old compulsions happen to occur in front of. Specific features of digital tools make compulsive responses easier to carry out, harder to resolve, and quicker to become automatic than their physical counterparts ever were. A second, narrower claim follows from that: because a digital compulsion is so cheap to add on top of an existing routine, it often does not replace a physical ritual so much as sit next to it, quietly taking up more of a person's day even when their visible, physical symptoms look no worse.

The rest of the paper runs as follows. Section 2 works through the literature this argument rests on, study by study, across the cognitive-behavioural account of compulsions, habit theory, problematic internet use, cyberchondria, and digital hoarding. Section 3 pulls that review together and places the proposed model against broader frameworks of digital and internet-use behaviour. Section 4 lays out the model itself. Section 5 goes through each classical OCD symptom dimension and asks what a digital equivalent might look like, and how much evidence already exists for it. Section 6 considers what this means for clinical assessment and, in particular, for exposure and response prevention (ERP). Section 7 asks why the model might matter especially in Indian clinical settings. Section 8 offers a short, hypothetical case to make the model concrete. Section 9 sets out how it could be tested, and Section 10 is honest about where it falls short.

REVIEW OF LITERATURE

This section works through the literature the paper draws on, organised into six areas: the cognitive-behavioural account of OCD, habit formation and automaticity, problematic and pathological internet use, cyberchondria, digital hoarding, and the treatment literature behind exposure and response prevention. It closes by naming the specific gap the rest of the paper tries to fill.

The Cognitive-Behavioural Account of Obsessive-Compulsive Disorder

Salkovskis (1985) laid out the cognitive-behavioural model that is still the reference point for almost all later work on OCD. His argument was that intrusive thoughts occur at similar rates in the general population and in people with OCD, so what actually distinguishes a clinical presentation is not the thought itself but how it gets appraised, as meaningful, as revealing something about the person's character, or as making them personally responsible for a harm they could still prevent. It is this inflated sense of responsibility, more than the thought, that the model treats as the thing needing explanation.

Rachman and Hodgson (1980) described the basic reinforcement loop behind compulsive behaviour: a ritual brings the distress down in the short term, and that relief reinforces the behaviour without touching the underlying appraisal, so the urge comes back at full strength next time. Rachman (2002) later extended this specifically to checking, arguing that repeated checking actually erodes confidence in memory and perception rather than restoring it, leaving the person less certain, and more likely to check again, each time.

McKay et al. (2004) reviewed the evidence for distinct OCD symptom subtypes and concluded that contamination and washing, doubt and checking, symmetry and ordering, and unacceptable thoughts and mental rituals are the dimensions that replicate most consistently. Mataix-Cols, do Rosario-Campos, and Leckman (2005) reviewed twelve factor-analytic studies covering more than 2,000 patients and arrived at a broadly similar structure, adding hoarding as a further dimension and noting that these dimensions differ from each other in comorbidity, treatment response, and neural correlates. Pinto et al. (2007) refined this picture further, reporting that taboo thoughts cluster closely with doubt and checking rather than forming their own dimension, a finding this paper draws on directly in Section 5.5.

Habit Formation and Automaticity

Wood and Neal (2007) proposed an influential account in which repeatedly pairing a context with a response eventually lets the context alone trigger the response, no active goal required, which explains why well-practised behaviours often keep running even after a person has stopped wanting to do them. Oulasvirta, Rattenbury, Ma, and Raita (2012) applied this idea to smartphone use and, using logging and diary methods, found that checking habits form through this same context-response pairing and are kept going by small, unpredictably delivered rewards rather than any ongoing decision to check. Their participants often described their own checking as something that happened to them rather than something they chose, which lines up closely with how OCD patients describe compulsions they know are excessive but still struggle to resist.

Problematic and Pathological Internet Use

Davis (2001) put forward one of the earliest cognitive-behavioural models of pathological internet use, drawing a line between a specific form built around one particular online activity and a more diffuse, generalised form kept going by broader maladaptive beliefs.

Brand, Young, Laier, Wölfling, and Potenza (2016) proposed the Interaction of Person-Affect-Cognition-Execution (I-PACE) model, now one of the dominant frameworks in behavioural-addiction research, which explains problematic internet use as the product of predisposing traits interacting with situational affective and cognitive responses and weakened executive control. Both of these models, though, were built to explain reward-driven, addiction-like use rather than anxiety-driven compulsive behaviour, a distinction the paper comes back to in Section 3.

Cyberchondria

White and Horvitz (2009) were among the first to document what would later be called cyberchondria. Analysing search-engine logs, they showed that a search for a common symptom frequently escalates, within the same session, toward searches for rare and serious illnesses. Starcevic and Berle (2013) proposed a working definition of cyberchondria as excessive, repeated online health searching that raises anxiety rather than settling it, and Starcevic, Berle, and Arnáez (2020) later summarised the evidence for treating it as a transdiagnostic pattern rather than a disorder of its own. Schenkel, Jungmann, Gropalis, and Withhöft (2021) carried out a systematic review and meta-analysis and found the strongest associations with health anxiety and intolerance of uncertainty, with obsessive-compulsive symptoms also showing up consistently, though more weakly.

Digital Hoarding

Van Bennekom, Blom, Vulink, and Denys (2015) published the first clinical case report of digital hoarding, describing a patient whose inability to delete digital photographs closely mirrored hoarding disorder, and argued it should be treated as a distinct manifestation of the same condition. Sweeten, Sillence, and Neave (2018) followed up with survey research showing that digital possessions can generate the same kind of emotional attachment and difficulty letting go as physical possessions do, while pointing out that essentially unlimited digital storage removes the one practical constraint that, in physical hoarding, eventually forces some kind of resolution.

Exposure and Response Prevention

Foa and Kozak (1986) set out the emotional-processing account behind modern ERP protocols, arguing that reducing fear requires first activating the fear structure and then supplying corrective information that disconfirms it. Abramowitz (2006) built this into a widely used clinical manual for ERP in OCD specifically, working through hierarchy construction and response-prevention instructions in detail. Marlatt and Gordon (1985) proposed relapse-prevention theory, arguing that lapses are best headed off by anticipating specific high-risk situations rather than treating them as unpredictable, an argument this paper returns to in Section 6.3.

Digital Access and Usage Data

DataReportal (2025), in its Digital 2025: India report, put the number of Indian internet users at 806 million at the start of 2025, or 55.3 percent of the population, up 6.5 percent on the year before, with most people getting online through a mobile phone. This is the figure behind the claims made in Sections 1 and 7 that Indian clinical settings are now seeing a population for whom smartphone-mediated daily life is a genuinely recent arrival.

Summary and Research Gap

Taken together, this literature settles three things. Compulsive behaviour in OCD runs on an appraisal-and-neutralisation loop that, in principle, does not care where the neutralising act happens (Salkovskis, 1985; Rachman, 2002). Habitual phone use forms and keeps going through context-response pairing that has nothing to do with addiction-based internet-use models (Wood & Neal, 2007; Oulasvirta et al., 2012). And two digital patterns that look a lot like OCD compulsions, cyberchondria and digital hoarding, are already documented in reasonable detail (Starcevic & Berle, 2013; van Bennekom et al., 2015). What none of it does is bring these three things together into one account of why compulsions migrate toward digital tools and what keeps them there. Each area has mostly been studied inside its own vocabulary, without reference to classical OCD theory as a shared frame. Sections 3 and 4 try to close that gap.

THEORETICAL POSITIONING

The review above lays out the psychological loop this paper starts from: an intrusive thought gets appraised as personally significant and dangerous (Salkovskis, 1985), a neutralising response follows and brings short-term relief that reinforces the behaviour without touching the appraisal underneath it (Rachman & Hodgson, 1980), and repeated checking in particular ends up undermining rather than building the confidence it was supposed to produce (Rachman, 2002). Nothing about this loop cares whether the neutralising act involves a tap, a switch, or a screen, and Oulasvirta et al.'s (2012) findings on habitual, goal-independent smartphone checking (Wood & Neal, 2007) show essentially the same mechanism running on the very devices this paper is concerned with.

The internet-use models covered in Section 2.3 are genuinely useful, and nothing here is meant to argue against them. But neither Davis's (2001) model nor Brand et al.'s (2016) I-PACE model was built with OCD specifically in mind, and that difference matters. Addiction-style frameworks like I-PACE are built around reward and craving, the person goes back to the behaviour because it feels good, or because not doing it feels bad in a way that resembles withdrawal. OCD compulsions are not reward-seeking in that sense. Rachman and Hodgson (1980) were explicit that the relief a compulsion brings is relief from anxiety the compulsion itself did not need to create in the first place, not pleasure. A model of digital compulsion built for OCD needs to keep the appraisal-driven, responsibility-laden structure of Salkovskis's (1985) and Rachman's (2002) accounts at its centre, and treat digital-specific features as things that amplify that structure rather than as a separate addictive process. Filling that gap is the job of the Compulsion Migration Model, set out next in Section 4.

THE COMPULSION MIGRATION MODEL

The model proposed here rests on one central idea. Whenever a digital equivalent of a compulsive response becomes available, three properties of digital environments make that equivalent more reinforcing than the physical version was. This raises the odds that the ritual migrates toward the digital option, becomes automatic there, and, this is the important part, persists alongside the original physical ritual rather than replacing it. Table 1 sets the model out as a five-stage sequence, moving from the classical starting point in cognitive-behavioural theory through to the specifically digital mechanisms this paper is proposing as new.

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Table 1. The Compulsion Migration Model as a five-stage sequence.

Stage	What Happens	Grounding in Existing Research
1. Appraisal	An intrusive thought is misread as personally significant and dangerous, creating a felt need to act.	Salkovskis, 1985; Rachman, 2002
2. Response Selection	A neutralising response is chosen; a digital option (searching, checking an app, photographing, saving) is now available alongside, or instead of, a physical one.	Rachman & Hodgson, 1980
3. Digital Amplification	Three features of digital tools, near-zero effort, ambiguous and endless information, and unpredictable reward, strengthen the response more than a physical ritual would be strengthened.	Oulasvirta et al., 2012; Schenkel et al., 2021; Davis, 2001
4. Habituation	With repetition, the response stops depending on conscious intention and starts firing automatically off situational cues.	Wood & Neal, 2007; Rachman, 2002
5. Layering	The digital ritual is added on top of the physical one rather than replacing it, so overall compulsive load increases rather than shifts.	van Bennekom et al., 2015; Sweeten et al., 2018

Three Properties That Amplify Digital Compulsions

The first property is effort. A physical compulsion usually costs something to perform: walking back to check a door, tracking down a family member to ask for reassurance, physically retrieving an object. A digital equivalent strips almost all of that cost away, the phone is already in the hand, the search bar is already open, the app is already installed. Response cost has long been recognised as a lever on how often a behaviour occurs, so removing it should, on ordinary learning principles, increase the frequency of the response, and this has nothing specifically to do with OCD.

The second property is informational ambiguity. Physical checking usually ends with a fairly clear answer: the door is locked, or it is not. Digital searching, especially around health, very often does not end at all. Health-related searches tend to return conflicting, alarming, or inconclusive results, which is exactly what the cyberchondria literature identifies as the reason the search keeps going instead of stopping (Schenkel et al., 2021; White & Horvitz, 2009). A physical ritual can, at least in principle, produce certainty. A digital one is often structurally built to produce more uncertainty than it resolves, which is a poor match for a disorder built around intolerance of uncertainty.

The third property is the reward pattern. Oulasvirta et al. (2012) show that checking habits are shaped by rewards that arrive unpredictably, a new message sometimes, nothing sometimes, rather than every time. Unpredictable reward schedules are well known to produce behaviour that resists extinction more than behaviour reinforced on every single occurrence. A physical ritual like hand-washing delivers roughly the same relief each time it is performed. A digital ritual like refreshing a feed or re-searching a symptom delivers a variable, unpredictable payoff, which by ordinary reinforcement principles should make it harder to stop, not easier.

The Layering Hypothesis

The more original claim in this model concerns what happens over time. It would be reasonable to expect digital compulsions simply to replace physical ones, that a person who once checked a physical lock now only checks an app, say. The case and survey literature on digital hoarding suggests the opposite is at least as common: van Bennekom et al. (2015) and Sweeten et al. (2018) both describe digital accumulation happening in people who also showed traditional hoarding features, not instead of them. This paper's proposal is that this pattern is not particular to hoarding but a general property of digital compulsions, because a digital ritual costs so little to perform, it rarely requires giving up the physical one to make room for it. The result, which I am calling layering, is that a person's total compulsive activity can rise even in cases where a clinician, going only by visible physical symptoms, would judge them to be doing well.

Mapping Classical Symptom Dimensions onto Digital Equivalents

Factor-analytic research on OCD keeps turning up a small number of stable symptom dimensions: doubt and harm and checking, symmetry and ordering, contamination and cleaning, hoarding, and unacceptable or taboo thoughts (McKay et al., 2004; Mataix-Cols et al., 2005). If digital compulsions are a general phenomenon and not just a quirk of health anxiety, each of these dimensions should, in principle, have a digital equivalent worth naming. This section goes through them one at a time, deliberately unevenly: some dimensions already have direct supporting literature, and that is stated plainly; others are extended from the model's logic alone and offered as hypotheses rather than findings. Table 2 summarises the mapping.

Table 2. Classical OCD symptom dimensions mapped onto proposed digital equivalents.

Classical Dimension	Proposed Digital Equivalent	Evidentiary Status
Doubt, harm, and checking	Repeated online searching for reassurance; re-checking sent messages, security or banking apps, a contact's online status.	Direct — supported by the cyberchondria literature (Starcevic & Berle, 2013; Schenkel et al., 2021).
Hoarding	Inability to delete photographs, screenshots, emails, or files despite recognising the accumulation as excessive.	Direct — supported by case and survey evidence (van Bennekom et al., 2015; Sweeten et al., 2018).
Symmetry and ordering	Repeated rearranging of files, folders, home-screen icons, or document formatting until it feels exactly right.	Speculative — plausible by extension from incompleteness-based accounts (Mataix-Cols et al., 2005) but not yet directly studied.
Contamination and washing	Repeated scanning, wiping, or factory-resetting of a device believed to be contaminated by a virus or unwanted data.	Speculative — the weakest fit in the model; bodily contamination has no obvious digital analogue, so this row is a hypothesis, not a finding.
Unacceptable or taboo thoughts	Repeatedly searching one's own browsing or message history for 'evidence' that a forbidden thought was acted on.	Plausible extension — consistent with mental-reviewing accounts of this dimension (Pinto et al., 2007) though not yet studied in digital form.

Doubt, Harm, and Checking

Of everything discussed here, this dimension has the most direct digital evidence, largely because cyberchondria research has already described it, just not in this language. Someone whose obsession centres on causing harm through carelessness, an appliance left on, a message that will be misread, a symptom missed in themselves or a family member, has, in a smartphone, a tool that offers to settle the doubt in seconds. Given the responsibility appraisal at the heart of Salkovskis's (1985) model, checking should migrate to digital tools more readily than almost any other dimension, precisely because a search engine or a checking app promises exactly the certainty the doubt is asking for, at a fraction of the effort a physical check would take.

Hoarding

Hoarding is the one dimension where a digital equivalent has already been named in the clinical literature (van Bennekom et al., 2015; Sweeten et al., 2018), covered in Section 2.5 and not repeated here in full. It is worth restating as the clearest existing demonstration of the layering hypothesis in particular: digital hoarding case material has tended to describe digital accumulation happening alongside traditional hoarding tendencies, not instead of them, which is exactly the pattern Section 4.2 proposes as general rather than specific to this one dimension.

Symmetry and Ordering

No published work yet describes a 'digital symmetry' compulsion directly, so this section is an extension of the model's logic rather than a summary of existing findings. Symmetry and ordering symptoms are usually understood as driven by a feeling of incompleteness rather than fear as such (Mataix-Cols et al., 2005); the action repeats not because something dangerous might happen but because it does not yet feel finished. Digital environments arguably give this feeling more precise and more endlessly adjustable targets than most physical objects do, a document's margins, spacing, and alignment can be nudged by fractions of a unit indefinitely, a home screen's icons can be dragged and reordered without limit, a playlist resequenced any number of times. If incompleteness is the driving sensation, a digital environment may not just host this dimension but make it structurally harder to satisfy, since the thing being arranged rarely pushes back the way a physical object eventually does. This is a testable prediction, and as far as I am aware, a new one, so it should be read as speculative until studied directly.

Contamination and Washing

This is the weakest fit in the model, and it is worth saying so plainly rather than stretching the argument to cover it. Contamination obsessions and washing compulsions are organised around a felt bodily threat, and there is no obvious digital action that neutralises a bodily sensation. Two tentative extensions are worth naming for future work. First, contamination-related doubt may still migrate toward digital checking, repeatedly searching for information about a contaminant or how effective a cleaning product is, but this arguably belongs to the checking dimension in Section 5.1 rather than a distinct digital form of washing. Second, and more speculatively, a person may come to fear that their phone or laptop is itself contaminated, by a virus or unwanted data, and respond with repeated scanning, wiping, or factory-resetting. Neither extension has empirical support at the time of writing, and this dimension stays an open question the model does not resolve.

Unacceptable or Taboo Thoughts

Taboo obsessions, unwanted sexual, violent, or blasphemous thoughts, are closely linked to mental reviewing and doubt/checking in factor-analytic work (Pinto et al., 2007), which points to a plausible, if not yet directly studied, digital extension. Someone troubled by the thought that they may have acted on a forbidden impulse without noticing at the time will often mentally review recent events, searching for reassurance that nothing happened. A phone turns this from an internal, fallible memory search into an external, seemingly objective one: browsing history, sent messages, and call logs can be checked and rechecked for 'evidence' either way. Because Rachman's (2002) account of checking holds that each check undermines confidence in the last one, an externalised record that can, in principle, be checked without limit may be harder to walk away from than a memory that eventually just feels resolved.

CLINICAL AND ASSESSMENT IMPLICATIONS

Symptom Mapping and Hierarchy-Building

If this model holds up, standard OCD symptom mapping, ERP hierarchies included, risks being incomplete if it is built only from physical rituals. A hierarchy that lists checking the stove or the door but never asks about checking a home-security app or a banking app may be missing a real share of a patient's compulsive activity, activity that, under the layering hypothesis, does not necessarily show up as a reduction anywhere else. In practice this could mean adding a few direct questions to intake interviews: which searches, apps, or checks does the patient turn to when an obsession is triggered, how often, and has this changed alongside any physical ritual.

Exposure and Response Prevention

This has a direct knock-on effect for response prevention. Standard ERP protocols (Foa & Kozak, 1986; Abramowitz, 2006) ask patients to withhold a specific ritual after a specific trigger. If a digital substitute exists and is not explicitly named and blocked during the exposure, a patient resists checking a physical lock but is still free to check a security-camera app, the trial can be undermined without either party noticing, since the physical target behaviour really was withheld. Digital response-prevention rules need the same precision as physical ones: which searches, apps, or checks are off-limits, and for how long. Built-in screen-time or app-blocking features can support this kind of agreement between sessions at no real cost, much as a physical object might be temporarily removed from a patient's environment.

Relapse Prevention and Clinician Training

The layering hypothesis also matters for the maintenance phase of treatment. Relapse-prevention work has long stressed anticipating high-risk situations rather than treating a lapse as unpredictable (Marlatt & Gordon, 1985); one specific high-risk pattern this model points to is a physical ritual that has genuinely reduced, giving false reassurance, while a digital equivalent quietly grows because nobody asked about it. A brief, direct check on digital ritual frequency alongside the usual physical symptom review would help here. More broadly, if digital compulsions are as widespread as the cyberchondria and digital hoarding literatures suggest, clinical training in OCD assessment may need to treat digital-symptom enquiry as a standard part of the interview rather than an optional extra, a modest change to existing training and supervision practice, not a call for new infrastructure.

RELEVANCE TO THE INDIAN CLINICAL CONTEXT

The argument developed here has a particular relevance to Indian clinical psychology that is worth spelling out. India's internet and smartphone adoption has been large in scale and unusually recent and fast: penetration rose from a small fraction of the population a decade and a half ago to more than 55 percent of a population above 1.4 billion by early 2025, mostly through mobile phones rather than computers (DataReportal, 2025). For a large share of patients now presenting to Indian clinical settings, the digital tools discussed here are a genuinely recent addition to daily life, which may make their role in symptom presentation easier to trace in a clinical history than in a population where smartphone use has been constant across the lifespan.

A second consideration is visibility. Physical compulsions such as handwashing, checking, or arranging are often noticed by family members, particularly in the joint or extended family arrangements still common across much of India, and that noticing frequently plays a part in bringing someone to treatment. A search performed on a personal phone leaves no such trace, so digital compulsions may stay hidden considerably longer before anyone recognises them as a problem. If that is right, the digital-symptom enquiry proposed in Section 6.1 may be doing more clinical work in Indian settings specifically, simply because it makes up for a larger gap in what is otherwise visible to the people around the patient. This is offered as a testable extension of the model to the local context, not a general claim about Indian patients.

AN ILLUSTRATIVE COMPOSITE CASE

The following is a hypothetical, composite illustration built for explanatory purposes only. It does not describe an actual patient, is not drawn from any specific clinical case, and should not be read as evidence for the model. It exists solely to make the five stages in Table 1 concrete.

Consider a hypothetical young adult with a longstanding fear of causing serious harm to a family member through carelessness. An intrusive thought, what if I left the gas stove on, gets appraised, following Salkovskis's (1985) model, as meaning the person is personally responsible for a fire that has not yet happened (Stage 1). Early on, the neutralising response is entirely physical: walking back to check the stove, sometimes several times before leaving (Stage 2). Over time the person starts instead, or in addition, opening a smart-home app that shows the stove's status remotely, nearly free to open, available even after leaving the house, and, because the sensor sometimes lags, not always resolving the doubt on the first check, so the check repeats (Stage 3). Within a few months, opening the app has become almost automatic, triggered by the sight of the front door rather than any deliberate decision (Stage 4). Crucially, the physical checking has not gone away; the person still occasionally walks back to look directly, on top of checking the app for the same single instance of leaving, so total time and effort spent on this one obsession has gone up rather than down (Stage 5). A clinician looking only at the physical checking, and noting with some satisfaction that it has become less frequent, would in this scenario be missing most of what is actually going on.

DIRECTIONS FOR EMPIRICAL VALIDATION

As a theoretical paper, this account makes claims that can be tested but have not been yet. Four predictions follow directly from the model. First, where a person has both a physical and a digital version of the same compulsion available, the digital version should show up more often and with a lower triggering threshold, since it carries a lower response cost,

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something assessable through self-monitoring logs that timestamp physical and digital instances separately. Second, digital hoarding and cyberchondria severity should each correlate more strongly with intolerance of uncertainty than with general anxiety severity, since the model attributes their persistence to unresolved ambiguity specifically, and this is testable through a fairly straightforward correlational study using existing validated measures. Third, and this is the prediction that most directly tests the layering hypothesis, total compulsive time, physical plus digital, summed, should predict functional impairment better than physical compulsive time alone, which would require studies that currently measure only one to start measuring both. Fourth, and this is where the model is most easily proven wrong, checking and hoarding should show a clearer digital migration pattern in structured interviews than contamination does, since Section 5.4 flags contamination as the weakest fit; if contamination turns out to show an equally strong pattern, the mechanism proposed here would need revising.

LIMITATIONS

This model is a synthesis of existing theory and largely separate findings. It has not been tested against original data, and every claim above should be read as a hypothesis rather than a result. It leans heavily on cyberchondria and digital hoarding, the two areas with the most direct literature, and its extension into symmetry, contamination, and taboo-thought dimensions in Section 5 rests on the model's internal logic rather than on direct findings, and may not hold up equally well once it is actually studied; that is stated plainly rather than glossed over. The account also does not resolve individual or cultural differences in access to digital tools, which will shape how much opportunity exists for migration in the first place; Section 7 raises this for the Indian context, but the claims made there are themselves untested extensions. Finally, self-report is a particular problem for testing this model, since people are known to underestimate their own device use, which could make digital ritual frequency harder to measure accurately than physical ritual frequency.

CONCLUSION

Compulsions have historically been described and treated as though the setting they occur in barely matters. This paper has reviewed the separate literatures on cognitive-behavioural models of OCD, habit formation, problematic internet use, cyberchondria, and digital hoarding, and has argued that the setting matters a great deal once it turns digital, because digital tools change effort, ambiguity, and reward in ways that classical learning theory would predict should strengthen a compulsive response rather than leave it unchanged. The Compulsion Migration Model offered here connects findings that have so far been read as separate topics, proposes that these are really instances of one process, and extends that process, with appropriate caution, across the full range of classical OCD symptom dimensions. Whether the specific mechanisms proposed here actually hold up is an empirical question this paper cannot settle on its own. What it can do is make the question askable in a more precise, clinically usable form than it has been asked before.

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Conflict of Interest

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