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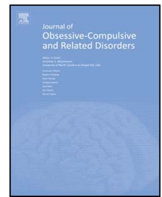

Short communication

Stigma and recognition of different types of symptoms in OCD

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ABSTRACT

Since stigma and poor illness recognition are two major barriers in seeking treatment for Obsessive-Compulsive Disorder (OCD), it is necessary to investigate the public's knowledge and perception of OCD in its many forms. The goal of the present study was to identify how stigma and recognition rates differed across four distinct symptom dimensions of OCD: contamination, symmetry, harm, and taboo content. In an online survey, 738 adults from the United States were randomly assigned to one of five vignettes describing an individual with obsessive-compulsive symptoms, followed by questionnaires assessing their reactions. The symmetry/incompleteness and contamination dimensions were significantly more likely to be labeled as OCD (84.5% and 76.1% recognition rates, respectively) than the responsibility for harm or taboo dimensions (36.9% and 30.9%, respectively). Participants in the taboo condition endorsed significantly higher levels of stigma for their character described in the vignette. Participants who labeled their vignette as OCD desired significantly less social distance and reported lower levels of fear than those who did not, regardless of condition. Our findings suggest that symptom content is a salient component of the social perception of OCD, and we discuss the relationship between mental illness recognition and stigma for this disorder.

1. Introduction

While obsessive-compulsive disorder (OCD) is often presented to the public *broadly* as a combination of function-impairing obsessions and compulsions (American Psychiatric Association, 2013), the content of these distressing thoughts can vary drastically. Often, researchers find that this variance clusters into four key dimensions: concerns about (a) contamination, (b) symmetry/incompleteness, (c) responsibility for harm, and (d) intrusive taboo thoughts (Abramowitz et al., 2010). Although these all fall under the domain of OCD, the social experience of people with a dominant symptom manifestation may differ in important ways. For instance, several studies have found that perceived public stigmatization and feelings of shame are higher among people with taboo thought content than among people with other dominant symptom presentations (Glazier, Wetterneck, Singh, & Williams, 2015; Weingarden & Renshaw, 2015). Indeed, studies have shown that members of the general public tend to view harm and taboo content-related thoughts as more socially unacceptable and threatening, and people suffering from these symptoms may be met with lower suggested disclosure (Beşiroğlu et al., 2010; Cathey & Wetterneck, 2013; Corcoran & Woody, 2008; Simonds & Thorpe, 2003). Given that stigma is likely one of the largest barriers to seeking treatment for OCD (García-Soriano, Rufer, Delsignore, & Weidt, 2014; Rüsch, Angermeyer, & Corrigan, 2005), these public perception differences may have important trickle-down implications for the significant percentage of OCD sufferers who choose not to avail themselves of professional psychological help (García-Soriano et al., 2014; Schwartz, Schlegl, Kuelz, & Voderholzer, 2013).

Mental illness recognition is an additional concern—the inability of individuals to recognize what they *or others* are experiencing very likely adds to OCD-treatment-seeking reluctance (Coles & Coleman, 2010; Rüsch, Evans-Lacko, Henderson, Flach, & Thornicroft, 2011). While it seems that most people recognize the symptoms of OCD as problematic (Coles & Coleman, 2010; Coles, Heimberg, & Weiss, 2013), there is a large amount of variability in the general public correctly recognizing OCD *as* OCD—recognition rates of OCD in survey and experimental studies range from 26–86.4% (Chong et al., 2016; Coles & Coleman, 2010; Coles et al., 2013; Koutoufa & Furnham, 2014; Warman, Phalen, & Martin, 2015). It is very important to note that in the aforementioned studies, each design described OCD using varying symptom content—in other words, the wide *range* of recognition rates between studies may reflect systematic differences in the

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sorts of symptoms that researchers have used to describe OCD to their participants. While violent thought OCD appears to be under-recognized, there has been mixed evidence on how often individuals recognize contamination and checking symptoms as OCD.[1] In addition, only one study to date has investigated *differences* in recognition rates between different symptom presentations directly; Glazier, Calixte, Rothschild, and Pinto (2013) found that taboo content obsessions—particularly sexual obsessions—were significantly less likely to be diagnosed as OCD compared to contamination obsessions in a sample of mental health professionals. To our knowledge, no study has compared recognition rates directly among members of the lay public.

In sum, the available evidence suggests that some varieties of OCD presentation are met with more public stigmatization and perhaps worse illness recognition—each of which conceivably may reduce OCD sufferers' likelihood of seeking professional psychological or psychiatric help—than others. We designed and conducted the present study in order to (a) provide a well-controlled experimental test of this new domain-specific framework for understanding public attitudes toward OCD and (b) investigate a novel hypothesis in attempting to characterize the manner in which recognition and stigma may interact with each other.

In our attempt to (a) replicate previous work, we used vignettes that were identical in every way but symptom specific content (i.e. general grammatical structure of the vignettes, illness severity, time taken by symptoms, and the demographics of the fictional character were held constant) in order to remove the impact of extraneous variables that may have impacted previous findings. In addition, we employed psychometrically validated measures of social distance and perceived fear/dangerousness to operationalize mental illness stigma (Corrigan, Markowtiz, Watson, Rowan, & Kubiak, 2003; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). On the basis of prior findings, we predicted that people would desire greater social distance from and report higher fear and more perceived dangerousness in reaction to a fictional character with taboo[2] and harm-related symptoms. In addition, we proposed to investigate differences in recognition rates between the contamination, symmetry/incompleteness, responsibility for harm, and taboo content symptom dimensions of OCD in a non-expert sample. The varying language, structure, and demographic profiles of prior studies' vignettes may very likely have influenced findings to date, and thus it is essential to use carefully crafted vignettes and compare them in a single design to uncover valid differences between symptom subtypes. Furthermore, important symptom dimensions such as symmetry/incompleteness have yet to be thoroughly investigated. We hypothesized that the responsibility for harm and taboo symptom dimensions would be less frequently recognized, or labeled, as OCD.

Our second aim was to (b) attempt to tease apart the complex relationship between OCD stigma, symptom (dimension) presentation, and illness recognition. Since education and accurate knowledge of mental disorders are associated with lower levels of stigma (Jorm & Oh, 2009; Rüsch et al., 2005), we reasoned that recognition of OCD (operationalized as labeling) might be associated with less OCD-stigmatizing attitudes. Warman et al. (2015) offered preliminary evidence for this notion; providing individuals with DSM-5 criteria for OCD resulted in lower levels of stigma for a hypothetical individual with violent intrusive thoughts, as well as an increased likelihood of agreeing with an OCD diagnosis. More so, Fox (2016) found a negative association between *believed* knowledge of OCD and endorsed levels of stigma, though did not investigate a form of actual knowledge. Discovering a simple association between recognition and stigma would bolster this emerging model of public attitudes toward OCD. Again, based on our interpretation of prior findings, we hypothesized participants who label OCD symptom presentations as OCD would report lower levels of stigma. Lastly, given that stigma and recognition seem to differ between presenting symptoms, it is also possible that the association between stigma and recognition itself varies between dimensions. We hypothesized there would be a significant interaction between labeling and stigma across the symptom dimensions. We believe the association between recognition and stigma will be stronger in the taboo and harm symptom conditions, such that those who recognize OCD will endorse lower levels of stigma in these conditions, while the relationship will be weaker in the symmetry and contamination conditions. Since we are considering recognition (via labeling) to be representative of having knowledge of OCD, it is plausible that its effect would be stronger for the symptom dimensions believed to be less understood by the public.

2. Method

2.1. Participants

Participants (N=738) were adults (ranging from ages 18 to 79) from the United States of America.[3] Table 1 provides demographic information for our sample.

2.2. Procedure

Participants were recruited and compensated $.20 to complete a survey through the online platform Amazon's Mechanical Turk (MTurk). MTurk has demonstrated the ability to provide reliable data from a fairly diverse sample (Buhrmester, Kwang, & Gosling, 2011), and has become a popular platform for clinical psychology research, particularly when studying stigma (Chandler & Shapiro, 2016). Participants were instructed to read one of five randomly assigned vignettes depicting an individual with various intrusive thoughts and related compulsions (see below). After reading the vignette, participants completed measures that assessed their perception and reaction to the vignette in the order presented below. Questions for multi-item scales were counterbalanced through randomization. Demographic items were presented at the end of the survey.

2.3. Materials/measures

2.3.1. Vignettes

Five vignettes were created for this study (see Appendix). Each vignette (M =96 words) depicted a 28-year-old man ("Taylor") with obsessional thoughts and accompanying compulsions. The vignette length was influenced by recommendations of prior research on vignette usage (Veloski, Tai, Evans, & Nash, 2005). Four of the five vignettes described clinical levels of OCD symptoms, which differed only in the symptom dimension of obsessions and compulsions; symmetry/incompleteness (n =148), contamination (n =142), responsibility for harm (n =160), and taboo content (n =149). The four vignettes were crafted to depict equally severe cases of OCD symptoms;

[1] Contamination symptoms have been recognized as OCD by as few as 28% (Chong et al., 2016) and by as many as 86% (Coles & Coleman, 2010) of participants. Roughly one out of every three participants recognized OCD when it was described with both contamination and checking symptoms (Coles et al., 2013). Another study averaged the recognition rate of two different OCD vignettes—one involved checking and the other contained both contamination and symmetry/incompleteness content—and found a recognition rate of 64%, though the individual rates for each vignette are not known (Koutoufa & Furnham, 2014). Only 26% of participants agreed with an OCD label of a person with intrusive thoughts about violence prior to an educational intervention (Warman, Phalen, & Martin, 2015).

[2] In the present study, we choose to investigate taboo content of a sexual nature, due to the existing research suggesting higher levels of stigma and lower recognition for this sub-category (Cathey & Wetterneck, 2013; Glazier et al., 2013).

[3] One-thousand individuals began the survey, however we removed those who did not complete the survey (including demographics), failed attention checks, or had scores on any scale 4 SDs above or below the mean, resulting in our final sample size. Removing these participants did not meaningfully change our results

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