



# What do Spanish adolescents think about obsessive-compulsive disorder? Mental health literacy and stigma associated with symmetry/order and aggression-related symptoms



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## ABSTRACT

Obsessive-compulsive disorder (OCD) is a frequent and disabling disorder with a long delay in seeking help that could partly be due to poor mental health literacy and stigmatizing attitudes. This study analyzes the mental health literacy and stigma associated with symmetry/order and aggression-related OCD in a Spanish adolescent sample. This age group was chosen because adolescence is a vulnerable period for the development of OCD, and adolescents are often reluctant to seek professional help. One hundred and two non-clinical adolescents read two vignettes describing symmetry/order and aggression-related OCD. Then, referring to these two vignettes, they answered questions related to problem recognition, causality perception, need for treatment, treatment recommendations, and stigma. Results show that a high percentage of adolescents recognize the interference of order- and aggression-related OCD, consider that a peer with order- or aggression-related OCD needs treatment, and would recommend a formal source of help. Although order symptoms are highly recognized as OCD by adolescents, aggression-related OCD is frequently misidentified as schizophrenia or depression. Results also show higher levels of stigmatizing attitudes in adolescents, associated with aggression-OCD (versus order-OCD), especially in male adolescents and adolescents with no previous experience with mental health services/providers. Results suggest the need to develop school-based programs emphasizing OCD content heterogeneity, especially the aggression, sexual, and religious contents, and work toward eliminating stigma.

## 1. Introduction

Obsessive-compulsive disorder (OCD) is a disabling disorder (World Health Organization, 1999) with a lifetime prevalence of 2.3% and a mean age of onset of 19.5 years (Ruscio et al., 2010). Nearly a quarter of adult males in the U.S. experience its onset before the age of 10, whereas in adult females in the U.S., the highest slope of new cases occurs during adolescence (Ruscio et al., 2010). These data contrast with the long treatment-seeking delay, which ranges between 3.28 (Spain) and 17 years (U.S.), and the high percentage of OCD sufferers, between 89.8% (Singapore) and 38% (England, Scotland and Wales), who never ask for or receive treatment for their disorder (García-Soriano et al., 2014). Differences in these delays could be explained by different health policies or socio-cultural factors. For example, in Spain, which has the shortest delay, there is a public health system, which could make it easier for people to ask for help sooner (Belloc et al., 2009). Moreover, in the studies reviewed, England, Scotland and Wales, which also have public health systems, showed the lowest percentages of OCD sufferers who did not ask for help. These

delays represent a serious public health problem associated with high costs for the individual, family, mental health system, and society (Hollander et al., 1999; National Institute for Health and Clinical Excellence, 2006).

The low levels of help-seeking behavior found among OCD patients can be explained by two different types of barriers. The first are those associated with mental health literacy (MHL), that is, the “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” in the community (Jorm et al., 1997, pp., 182). Some of the most relevant variables related to MHL include not knowing where to find help, the idea that they can manage their symptoms, and being ashamed to tell others about their symptoms or ask for treatment (for a review García-Soriano et al., 2014). The second group of barriers that could explain the difficulties in seeking help are associated with the stigma, or perceived stigma, associated with mental illness in general, and OCD in particular (Belloc et al., 2009; Williams et al., 2012). Therefore, examining the levels of MHL and stigma in a given population could help to develop intervention programs designed to increase the recognition of OCD and the use of mental health

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services.

The few studies that have analyzed mental health literacy in OCD have focused on analyzing the knowledge of different populations through reading vignettes that describe the contamination symptoms of an OCD patient (Coles et al., 2013; Coles and Coleman, 2010; Fernández de la Cruz et al., 2015). Results show that most participants recommend seeking help, ranging between 81.3% in a study with American undergraduates (Coles and Coleman, 2010) and 95.2% in a study asking a sample of British parents of children under 18 years old to imagine that their child had similar difficulties to those of the child in the vignette (Fernández de la Cruz et al., 2015). However, there are differences between studies in the recognition of OCD contamination in vignettes. Whereas only 33% of American community participants (Coles et al., 2013) and 28.7% of Singapore residents (Chong et al., 2016) identified the vignette as OCD, this percentage was higher in participants with studies related to psychology, as in the case of American undergraduate students enrolled in an Introductory Psychology course (86.7%; Coles and Coleman, 2010), and mental health care providers (84.15%; Glazier, Calixte, Rothschild, and Pinto, 2013). In the study with American undergraduates (Coles and Coleman, 2010), the most frequent causes of OCD were mental illness and biological variables, whereas in the study conducted with British parents (Fernández de la Cruz et al., 2015), OCD in children was attributed first to personality and emotional struggles, and second to trauma experienced by the child. Nevertheless, the identification rates of OCD in vignettes were much lower when participants were asked about OCD manifestations other than contamination. Thus, Glazier et al. (2013) found that 77% and 42.9% of mental health care providers misidentified obsessions about homosexuality and sexual obsessions about children, respectively.

As mentioned above, another barrier frequently associated with the delay in seeking help consists of the stigma associated with mental health, which frequently motivates patients and their families to keep the OCD diagnosis secret (Ociskova et al., 2013). Along these lines, Coles et al. (2013) reported that 14.7% of the American community sample recommended not talking about the contamination symptoms when reading a vignette describing these symptoms. In a study conducted with American young people (between 8 and 17 years old), OCD patients showed higher rates of peer victimization than healthy and type I-diabetes control groups (Storch et al., 2006). Different studies suggest that stigma could differ depending on the main OCD symptoms. Obsessions about violent, sexual, or blasphemous obsessions/themes have been associated with higher levels of shame and concealment by patients (Newth and Rachman, 2001). Moreover, Simonds and Thorpe (2003) reported that British first-year psychology undergraduates rated harming symptoms as more unacceptable (shame, fear, negative social evaluation) than washing and checking symptoms, which could explain, at least partly, why it is more difficult for OCD patients with harm thoughts to disclose them and seek help. In the same vein, Cathey and Wetterneck (2013) reported that individuals were less likely to report their intrusions if they had sexual content than if they had contamination content, with the disclosure of sexual intrusions being more associated with social rejection from others.

In the research on OCD-related MHL and stigma, two lines of interest have not been addressed. On the one hand, as reported above, only a few studies have analyzed the MHL about OCD, and these studies have focused on contamination OCD. However, rates of identification could be much lower for other OCD manifestations that have not received as much attention in the mass media (Cathey and Wetterneck, 2013; Fennell and Boyd, 2014). Moreover, research shows that contamination OCD seems to be less associated with stigma than other manifestations. On the other hand, there is no research on OCD recognition in the adolescent population, although studies conducted in different countries show poor recognition of other disorders, such as depression, schizophrenia, or social anxiety, and that only a minority

recommend seeking help (Burns and Rapee, 2006; Coles et al., 2016; Melas et al., 2013). Adolescents are an especially relevant target population, as they are highly vulnerable to developing OCD (Stengler et al., 2013) and reluctant to seek professional help, as they prefer to talk to friends (Raviv et al., 2000; Rickwood et al., 2007). Thus, they could play a relevant role in helping others to seek professional help or in seeking help for themselves if they have OCD symptoms. Furthermore, there are no studies appraising MHL and stigma related to OCD in the Spanish non-clinical population. With these three points in mind, the objective of the present study was to analyze, in a Spanish adolescent sample, the recognition and stigma associated with two OCD symptom contents: symmetry/order and aggression, also considering previous experience with mental health services/providers and participants' gender. We hypothesized that: (1) participants will show lower rates of MHL associated with aggression-OCD symptoms than with order-OCD symptoms, as the latter are more frequently reported in the mass media (e.g., movies such as *good as it gets* or *The Aviator*); (2) participants will show higher stigma associated with aggression-OCD symptoms than with order-OCD symptoms; (3) MHL associated with order-OCD symptoms will be similar to what is reported in the literature for contamination-OCD; (4) participants who have previous experience with mental health services/providers will show lower stigma levels.

## 2. Method

### 2.1. Sample

A group of 102 Spanish teenagers enrolled in a High School participated in this study (52.9% were juniors – first year of pre-university studies - and 48 were seniors -second year of pre-university studies-). Participants' mean age was 16.99 (SD=0.81) years old (ranging between 16 and 19 years old), and half of them were women (n=51). No exclusion criteria were applied in the recruitment of the sample.

Most of the participants (69.6%, n=71) had never had previous contact with mental health services or providers, 27.5% reported previous sporadic contact, and only 2.8% of the participants reported frequent contact with mental health services/providers. There were no between-gender differences in participants' previous experience with mental health services/providers ( $X^2(1)=0.046$ ,  $p=0.830$ ).

### 2.2. Instruments

First, participants were asked some socio-demographic questions, including age, gender, previous experience with mental health services or providers, and the frequency of this experience (i.e., just once, sometimes [sporadic contact] or frequent contact).

Then, we used a vignette-based questionnaire developed specifically for this study to assess the mental health and stigma associated with OCD. Following Gould (1996), and in order to establish the internal consistency, the vignette's development was based on vignettes reported in published studies (Coles et al., 2013; Coles and Coleman, 2010; Corrigan, 2012; Jorm, 2000; Reavley et al., 2014) and clinical OCD descriptions. First, it includes a vignette describing a 16-year-old boy/girl in different situations who showed OCD symptoms that caused significant interference in his/her life. There were two versions of the vignette, one describing order/symmetry OCD symptoms, and the other describing aggression OCD symptoms. The vignette is included in Appendix 1.

After reading each vignette, participants were asked four questions about the vignette that assessed different variables related to mental health literacy: (1) Problem recognition (*Is something wrong with the person described in the vignette?* -response alternatives: yes, no-; *If there is something wrong, what is the problem?* -response alternatives: generalized anxiety disorder, OCD, major depression, schizo-

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