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Mental health literacy and obsessive–compulsive personality disorder

Iakovina Koutoufa [a], Adrian Furnham [a,b,*]

[a] Research Department of Clinical, Educational and Health Psychology, University College London, 26 Bedford Way, London WC1H 0AP, UK
[b] Norwegian Business School, Nydalsveien, Oslo, Norway

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ABSTRACT

An opportunistic sample of 342 participants completed a vignette identification task that required them to name the possible psychological problem of an individual described in vignettes describing people with depression, schizophrenia, OCD and OCPD. Participants rated the degree to which they believed the individual experienced distress, they felt sympathetic towards the described individual, and the degree to which they believed the individual was well-adjusted in the community. There were very low recognition rates of OCPD, with participants more likely to identify depression, schizophrenia and OCD. Analysis of distress, sympathy and adjustment ratings also revealed significant differences between the disorders. The findings highlight the necessity of greater mental health awareness and the importance of psycho-education in order to increase successful treatment seeking of OCPD patients.

1. Introduction

Mental Health Literacy (MHL) is defined as 'the knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm et al., 1997). Jorm's (2000) review highlighted that a great majority of members of the public could not recognise mental disorders or pathological distress. For example, Jorm et al. (1997) found that 39% of the participants were able to label depression, but only 27% of them correctly identified schizophrenia. More recent studies have reported higher recognition rates on depression and schizophrenia: namely 97% for depression and 61% for schizophrenia but only 39% for anti-social personality disorder (Furnham et al., 2009). However, this increase in mental health literacy may not reflect an increase in awareness, but may be the result of methodological differences in the assessment and measurement of mental health literacy in different samples (Furnham and Dadabhoy, 2012). Yet recent longitudinal research has provided evidence of real positive changes over time in MHL (Reavley and Jorm, in press).

Various demographic variables have also been found to have an effect on mental health literacy. Fischer and Goldney (2003) found that younger and more educated people have more informed beliefs about mental illnesses. Gender has also been found to have a significant effect on identification of disorders (Furnham et al., in press). Riedel-Heller et al. (2005) found that females were more likely to suggest psychotherapy as a treatment for depression and schizophrenia than psychotropic drugs. Culture may also have an impact on the explanatory models and attitudes towards mental health literacy (Kleinman, 1988) and can determine motivations and treatment decisions (Rogler and Cortes, 1993). Jorm et al. (1997) also suggested that contact with a mental patient affects the lay beliefs in the sense that they become better informed about the cause and manifestation of mental illnesses. Lauber et al. (2003) also found that previous contact with a mental patient increased recognition of depression.

Schomerus et al. (2013) investigated the consequence of what they called continuum beliefs (as opposed to categorical beliefs) about people with various mental illnesses. They found, as predicted, that continuum beliefs were associated with less stigmatising attitudes, particularly with regard to schizophrenia and alcohol dependence suggesting the importance of educating people about the continuous nature of most psychopathological phenomena.

Furnham and Winceslaus (2012) found the majority of their participants failed to recognise the personality disorders. The disorder that yielded the highest recognition rate was paranoid personality disorder, identified by only 36% of participants. Similarly, Furnham et al. (2011) found that a large proportion of their participants perceived a psychological problem as present, but very few of them were able to 'correctly' label the personality disorders. One of their hypotheses was that Obsessive–Compulsive Personality Disorder (OCPD) would be identified more due to its extensive projection in the media compared to other disorders. Although it yielded one of the highest scores in correct labelling, OCPD was recognised as a psychological problem by less than half of their participants.

A highly salient paper for this research area is a study by Coles et al. (2013) on the public's knowledge of OCD. In all 575 American adults took part in a telephone interview study and they found 90% reported that they symptoms were a cause of concern and

* Corresponding author at: Research Department of Clinical, Educational and Health Psychology, University College London, 26 Bedford Way, London WC1H 0AP, UK. Tel.: +44 2076795395.
E-mail address: a.furnham@ucl.ac.uk (A. Furnham).

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that the person described should seek professional help. They noted that only a third of the respondents labelled the disorder correctly as OCD, Better educated, higher social class and younger people were better at correctly labelling the symptoms. Interestingly the respondents were more hopeful of the success of psychotherapy than medication as a cure.

This study concerned the recognition of OCPD which is a Cluster C personality disorder, according to the DSM classification system. It is, according to DSM-V (American Psychiatric Association, 2013) one of the most common of the personality disorders with an estimated prevalence from 2.1 to 7.9% of the population, diagnosed twice as often in males compared to females. There has been a heated debate regarding OCPD's relation to obsessive–compulsive disorder (OCD), with the two extreme standpoints claiming either that OCPD is completely unrelated to OCD or that OCPD is a prerequisite for the development of OCD. However, most individuals with OCD do not have a pattern of behaviour that fulfils the criteria for OCPD (Mancebo et al., 2005). Additionally, it is argued that OCPD is an egosyntonic disorder, implying that the symptoms are in congruency with the individual's goals and desires, whereas OCD is egodystonic, which means that symptoms cause distress and anxiety to the individual who recognises the abnormal nature of the symptoms (Taylor et al., 2011). Few studies have looked specifically at the mental health literacy of OCD and OCPD particularly how they compared with one another and the more commonly researched schizophrenia.

It is suggested by MHL researchers that recognition of mental illness has benefits because people with particular conditions are more sympathetically dealt with and offer more and better (more professional) help. This seems to be the case where there are evidence-based treatments but the same may not be the case for OCPD. Indeed there seems to be very little evidence for the availability, feasibility or proven efficacy of any treatment for OCPD (de Reus and Emmelkamp, 2010) which would make the task near impossible for a person eager to help themselves and/or others who they suspected had the condition. However given the fact that many people with personality disorder fail to recognise their symptoms it often behoves others like family members who, with better MHL, may offer help and advice.

This study aims to investigate the ability of lay people to identify OCPD as a psychological illness and to evaluate the individual's adjustment in the community. The first hypothesis (H1) was that OCPD will be significantly less recognised than depression, schizophrenia and OCD (Furnham et al., 2011). The second hypothesis (H2) was that lay ratings of distress and sympathy will be lower and adjustment ratings of the individual will be higher for OCPD individuals than other disorders (Furnham et al., 2011). The third hypothesis (H3) is that higher sympathy and adjustment but lower distress scores will predict increased obsessive symptoms due to the egosyntonic nature of OCPD and the theory that obsessive thoughts are in a continuum in the population and it is frequency and intensity that defines clinical pathology of obsessions and compulsions (Berry and Laskey, 2012). The fourth hypothesis (H4) is that gender (H4a), personal experience of mental illness (H4b), study of psychology (H4c) and contact with a mental patient (H4d) would predict mental health literacy of OCPD and ratings of distress, sympathy and adjustment.

2. Method

2.1. Participants

A total of 342 participants took part in this study, of whom 129 were male (37.7%) and 213 were female (62.3%). The age range of participants was between 18 and 65 years ($M=23.31$, S.D. = 12.03). The majority of participants were White (69.0%, $N=236$), with the remainder being Asian (21.3%, $N=73$), mixed (4.7%, $N=16$), Black African-Caribbean (1.2%, $N=4$), Hispanic (0.6%, $N=2$), or other (3.2%, $N=11$). The majority held a high-school diploma (43.0%, $N=147$), 33.6% ($N=115$) held an undergraduate degree, 11.7% ($N=40$) held a postgraduate degree, 2.6% ($N=9$) held other higher qualifications, 2.4% ($N=8$) held GCSEs/American 10th grade, 2.9% ($N=10$) had graduated a foundation course and 3.8% ($N=13$) held no academic qualifications. Regarding their occupational status, many of the respondents were students (75.4%, $N=258$), but there were also some participants in professional occupations (9.6%, $N=33$), intermediate occupations (10.5%, $N=36$), skilled occupations (1.8%, $N=6$), semi-skilled occupations (0.9%, $N=3$), unskilled occupations (0.3%, $N=1$), or other types of occupations (i.e. Armed Forces) (1.5%, $N=5$). The minority of participants had not studied Psychology (26.0%) or Psychiatry (7.5%). Additionally, most of the participants had not been diagnosed with a mental disorder (95.0%, $N=325$). The most common disorders among participants who had been diagnosed with a mental disorder (5.0%, $N=17$) were depression (41.2%, $N=7$) and anxiety disorders including OCD (35.3%, $N=6$). More than half of the respondents (53.2%, $N=182$) had known someone who has been diagnosed with a mental disorder. The majority had known someone who has been diagnosed with depression (48.4%, $N=88$).

2.2. Measures

Vignettes. The questionnaire consisted of five vignettes, describing one case of depression, one case of OCPD, one case of schizophrenia and two cases of OCD to check for reliability given that this is an issue in this research area (Sai and Furnham, 2013). The data for the two OCD cases were combined to attempt to ensure greater reliability in the analysis. The vignette describing a depressive patient was adapted from Jorm et al. (2006) and the vignette describing the schizophrenia case was adapted from Link et al. (1999). The OCPD vignette was adapted from Furnham and Winceslaus (2012). The first OCD (OCD1) vignette was adapted from Pirutinsky et al. (2009) and the second OCD (OCD2) vignette was adapted from a training programme developed by Coyle (2002). All of the vignettes were typical cases in order to demonstrate the criteria of each disorder in an easily comprehensible manner. The vignettes' length ranged from 71 to 205 (words). Half the participants completed the male version and the other half the female version of each vignette (see Appendix). In both versions the vignettes were presented in the order of depression, OCPD, schizophrenia, OCD1 and OCD2.

After each vignette participants were asked to answer an open-ended question 'What, if anything, would you say is X's main problem?' There was a qualitative content analysis on the participant's responses for maximal response identification. Participants' responses to this question were also categorised as either 'correct' or 'incorrect' in order to determine how many participants correctly identified each vignette. For the depression vignette, correct answers were considered to be 'depression' and 'depressed'. For the schizophrenia vignette, 'paranoid schizophrenia', 'schizophrenia' and 'schizophrenic' were deemed correct. For the OCPD vignette, 'obsessive–compulsive personality disorder' and 'OCPD' were deemed correct. Finally, for the OCD vignette, 'compulsive disorder', 'OCD', 'obsessive' and 'obsessive–compulsive behaviour' was deemed correct. There were essentially two ways to get either a correct or incorrect score: if the answer used the above labels or suggested the person understood the condition the answer was considered correct; if there was no response, or an incorrect label or description was used the response was considered incorrect.

After each vignette there were *five* questions based on a Likert scale ranging from 1 (Not at all) to 7 (Extremely). These questions' scope was to evaluate the degree to which participants felt sympathetic towards the described patient and whether they found the patient's condition distressing. Additionally, they evaluated the degree to which they thought the patient was happy, successful at their work or school, and satisfied with their personal relationships.

2.3. Procedure

The study was approved by the appropriate college ethics committee. The questionnaire was distributed either in its online form (mass emails) or in person using an opportunistic sampling method, in an effort to obtain a representative sample. Non-student participants were recruited by the second author at various non-academic conferences he attended. Approximately half completed the study on-line and half by paper copy. Analysis showed fewer than chance significant differences in either the demographics or responses of the two groups. All participants signed a consent form prior to their participation and they were all informed of the anonymous and confidential nature of the questionnaire. No remuneration was offered. Participants were informed that the questionnaire was regarding their beliefs and attitudes towards the mentally ill. Those who completed the paper copy were debriefed and thanked for their participation.

3. Results

3.1. Vignette identification analysis

Gender of patient described in the vignette was counterbalanced successfully as there were no significant differences in the