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Impact of a brief education about mental illness on stigma of OCD and violent thoughts

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ABSTRACT

Obsessive–compulsive disorder (OCD) has been largely ignored in the stigma literature. The present study examined perceptions of violent thoughts that varied in terms of the diagnostic label – OCD, Schizophrenia, or no diagnostic label – assigned to a target experiencing such thoughts. Participants were randomly assigned to read a vignette about a target with one of the three diagnostic labels. Participants then completed measures of social distance and reported how dangerous and unpredictable they found the target, in addition to providing the diagnosis they believed the target had. They were then given a brief education about OCD and Schizophrenia and asked to complete assessments again. Results indicated that while an OCD diagnosis was not credible before education, it became the most credible diagnosis following education. Results indicated that education resulted in significantly decreased negative attitudes toward the target, which was accounted for by the shift to determining that the target had OCD.

1. Introduction

The value of education in informing the public about various mental disorders has a considerable history (Corrigan & Penn, 1999; Rüsch, Angermeyer, & Corrigan, 2005). Stigma towards individuals with mental disorders is extensive (see Jorm & Oh 2009), and is often considered to be a product of misinformation about the disorders (e.g., Penn, Kommana, Mansfield, & Link, 1999). Although not all attempts to decrease stigma through informational avenues have been successful (Corrigan & Penn, 1999), reducing misinformation or increasing knowledge of mental disorders is likely a fruitful way to decrease negative attitudes towards individuals with such disorders (e.g., Mino, Yasuda, Tsuda, & Shimodera, 2001).

One of the most significant contributors to stigma, or the desire to distance oneself from someone with a mental disorder, is the fear that individuals with mental disorders are dangerous and unpredictable (Angermeyer & Dietrich, 2006). Fears and/or distaste towards individuals with mental disorders are so powerful that just adding a diagnostic label to information related to a participant increases negative attitudes towards a hypothetical target relative to an identical target with no diagnostic label or a label that is not related to a psychiatric diagnosis (Arkar & Eker, 1994; Nieradzik & Cochrane, 1985). Although fears of individuals with mental illnesses are generally gross exaggerations of actual dangerousness, these fears can be challenging to alleviate (e.g., Penn & Link, 2002). Of the numerous disorders that have been examined in terms of stigma towards individuals with mental disorders, Schizophrenia has emerged as one of the most stigmatized disorders, in part due to the fear people have of individuals with this disorder (Jorm & Oh, 2009; Jorm, Reavley, & Ross, 2012). It is interesting to note, when one considers the high rates of "taboo" violent thoughts in Obsessive–Compulsive Disorder (OCD; Brakoulias et al., 2013), how understudied attitudes towards violent thoughts associated with OCD are in the stigma literature. Indeed this gap in the literature is compelling when one considers the association between fears of danger and stigmatizing beliefs towards individuals with mental illness.

Although there is minimal research into public attitudes towards and information about individuals with OCD, what existing data indicates is that the public does not know much about the disorder. For example, when presented with a vignette of an individual with various obsessions, participants acknowledged that the target likely had a psychological problem, but they were unable to determine what that problem was (Coles, Heimberg, & Weiss, 2013). This challenge extends even to mental health professionals (Wahl et al., 2010), who struggle with identifying the diagnosis of individuals with taboo thoughts in comparison to targets with the more typical contamination obsessions of OCD (Glazier, Calixte, Rothschild, & Pinto, 2013). Interestingly, investigation of taboo thoughts specifically is minimal in the stigma literature. One study that used vignettes of three different types of presentations of OCD symptoms – a compulsive washer, a compulsive checker, or a person with violent thoughts found that the

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individual in the violent thoughts vignette was perceived in the most negative light (Simonds & Thorpe, 2003). Similarly, Corcoran and Woody, 2008 found, in a creative study using vignettes to determine perceptions of hypothetical individuals with various common themes of intrusive thoughts – blasphemous, sexual, and violent – that the individuals with violent intrusive thoughts were perceived most negatively. When one considers that a considerable amount of the social distance desired from individuals with other psychological disorders is generally seen as a product of fear of the target or the perception that he/she is dangerous (Angermeyer & Dietrich, 2006) the fact that individuals with intrusive violent thoughts are viewed so negatively may not be surprising. Unfortunately, shame regarding symptoms in OCD sufferers is a significant barrier in seeking treatment (e.g., García-Soriano, Rufer, Delsignore, & Weidt, 2014), and with negative attitudes towards violent intrusive thoughts so high, it appears valuable to consider how education may impact these attitudes.

It is interesting that of the minimal research conducted to date of intrusive violent thoughts, no studies have manipulated or provided a label for such experiences. Instead, attributions of the thoughts are made in the absence of a label and participants are asked to make sense of such experiences (e.g., Corcoran & Woody, 2008). One way researchers have attempted to understand how individuals evaluate various hypothetical targets with other disorders has been to manipulate the diagnosis, or label, that is assigned to the target. Indeed, the label given to a person with various symptoms or behaviors can have considerable impact. Demonstrating the influence labels can have, individuals labeled with a mental health diagnosis are seen more negatively than individuals with the identical experiences who are labeled as having such experiences due to a physical illness (Socall & Holtgraves, 1992). Interestingly, who assigns the label may be less important than the label that is ultimately assigned to the person. When participants are asked to draw conclusions about a target based on behaviors or symptoms outlined in a vignette, participant-labeling of the target as mentally ill, regardless of disorder, is related to increases in social distance desired from that target (Angermeyer & Matschinger, 2005). It appears, then, that diagnoses and labels, when provided to a participant or when they are participant-determined, can evoke negative evaluations of a target.

It remains unclear whether psychoeducation can improve the negative perceptions of individuals with violent thoughts and lessen the negative attitudes towards individuals who suffer such thoughts. Further, is it unknown if education can be so powerful that it could even change perceptions of and labels assigned to individuals with violent thoughts if they were originally provided a diagnosis to help explain the violent thoughts. The present study aims to answer these questions.

For the present study, individuals were randomly assigned to read one of three vignettes that described a person with violent thoughts. In one group, no diagnosis was specified, in a second group, the only modification to the vignette was that a doctor noted that the target had obsessive–compulsive disorder, and in a third vignette the doctor noted the target had Schizophrenia. Participants' perspectives of the target's diagnosis were assessed, as was social distance desired from the target, perceived dangerousness, and unpredictability of the target. Participants were also asked what diagnosis they thought the person in the vignette had. Participants were then provided information, directly from DSM-5 (American Psychiatric Association, 2013), about obsessive–compulsive disorder and about Schizophrenia. After reviewing the information about the diagnoses, they read the vignette again and performed all the assessments again, including a diagnosis for the person in the vignette.

The present study had multiple aims. First, the present study aimed to determine the impact of label assigned to the target in terms of perceptions of the target, both the label provided *to* participants and the label provided *by* the participants. It was expected that targets who were given the label "OCD" in the vignettes would be perceived more positively (e.g., less social distance would be desired from them and they would be seen as less dangerous and unpredictable) than individuals who were given the label "Schizophrenia," given how poorly Schizophrenia is perceived (Jorm & Oh, 2009). It was expected, however, that the OCD label would not be particularly credible to participants before the education intervention, as the public as very poor at recognizing OCD (e.g., Glazier, Calixte, Rothschild, & Pinto, 2013). Specifically, it was expected that participants would largely reject the OCD label that was provided to them and provide a diagnosis other than OCD when asked to determine a diagnosis for him. This was not expected for the target who was labeled with Schizophrenia in the vignette; it was expected that the Schizophrenia label would be quite credible to participants before the education intervention and most participants would diagnose him with Schizophrenia when asked their opinion of the target's diagnosis, as violent thoughts and/or dangerousness are often associated with Schizophrenia (e.g., Jorm et al., 2012). In terms of participant-determined diagnosis, a similar pattern of results was expected. It was expected that participants would see targets they perceived as having Schizophrenia in a more negative light than targets they perceived as having OCD. The present study also aimed to determine the potential value of an education intervention on both the perception of the target with violent thoughts and also the possibility that the person in the vignette had OCD. It was expected that education would result in decreased desire for social distance from the target, and it was anticipated that an OCD diagnosis would become significantly more credible following the education.

2. Method

2.1. Participants

90 students were recruited from a University in the American Midwest. In order to participate in this study, participants had to be over 18 and speak English fluently. There were no other exclusion criteria. Students received course credit for participating. Thirty-eight participants (41.8%) were majoring in psychology, and all were enrolled in a psychology course at the time of participation. Each participant provided informed consent for participation and voluntarily agreed to participate. Participant characteristics are shown in Table 1. The present study was approved by the institution's IRB.

2.2. Materials

2.2.1. Vignettes

Participants were randomly assigned to read one of three vignettes each describing a person who often experiences violent thoughts of stabbing his niece (adapted from Corcoran & Woody, 2008), but who has no violent history. The vignettes for each of the conditions are presented below.

No label condition: Steve is a 20 year old male. Often when he is with his six-year-old niece, he has thoughts about stabbing his niece with a sharp kitchen knife.

Table 1
Participant characteristics.

	N	%
Gender		
Male	11	12.20%
Female	79	87.80%
Race		
Caucasian	76	84.40%
African-American	5	5.60%
Latino	2	2.20%
Asian	3	3.30%
Other	4	4.40%
	Mean (*SD*)	Min–max
Age	20.31(2.89)	18–41