Mental Health Literacy of OCD and OCPD in a Rural Area

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Abstract
This study examined the mental health literacy of Obsessive Compulsive Disorder (OCD) and Obsessive Compulsive Personality Disorder (OCPD) among the rural public. 89 volunteer participants (ages 19-86) completed this study using vignette methodology and a questionnaire. Results supported the hypothesis that mental health literacy would be low, specifically for OCPD. In addition, the majority of participants viewed the disorders similarly. The findings suggest that the current understanding of OCD may not reflect the disorders true diagnostic criteria and that participants viewed both disorders similarly in regards to treatment and stigma. Implications and further recommendations are discussed.

Mental health literacy, first coined by Jorm, Korten, Jacomb, Christensen, Rodgers, and Pollitt (1997), is defined as the “knowledge and beliefs specifically about mental disorders which aid their recognition, management, or prevention” (p. 182). For mental health literacy to be high, one must be able to identify particular disorders and know how and when to seek mental health resources (Jorm, et. al., 1997). Knowing this information will allow one to evaluate when and to whom they should go to for help, which could lead to proper symptom management. Mental health literacy is crucial for the recognition and early intervention of mental health disorders. The lifetime prevalence of any mental health disorder is 46.4%, meaning that close to half of the American population will be diagnosed with a disorder in their lifetime (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). It is likely that almost every person has had or will have contact with someone with a mental disorder. However, with the exception of depression and schizophrenia (Furnham & Blythe, 2012; Jorm, 2012), recognition and the ability to name mental health disorders is generally low (Jorm, 2000; Jorm, Christensen, & Griffiths, 2006; Jorm, et al., 2006; Jorm, et al., 1997).

Recognition of mental health disorders is important in order for patients to communicate with their physician or clinician in a manner that facilitates detection and ideally early intervention (Jorm, 2000). It is critical for the general public to be literate in all aspects of mental health in order to encourage proper help-seeking behaviors. Lack of knowledge can make it difficult for someone to receive treatment for a number of reasons. People may put off treatment because they do not know the available options, they have negative views about treatment, or have a fear of being stigmatized (Jorm, 2000). These obstacles might be compounded in rural areas where there are higher rates of illiteracy, access to mental health services is limited, and fear of stigma may be heightened (Wagenfield, 2003). In fact, the Committee on Rural Health, developed by
the American Psychological Association, was created in recognition of the unique concerns and behavioral health needs of rural communities and residents. There are a large number of rural residents who lack health insurance or are unable to afford services (Gale & Lambert, 2006). This stressor can be a barrier to treatment and may put a person at greater risk for mental health concerns (Gale & Deprez, 2003) or delay help-seeking (Gale & Lambert, 2006; Schank, Helbok, Haldeman, & Gallardo, 2010). Additional stressors that those living in rural areas experience are poor road conditions, bad weather, lack of transportation, and long travel distances to receive mental health services (Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Sawyer, Gale, & Lambert, 2006; Smith, 2003). This can inhibit opportunities for adequate mental health care in rural areas compared to urban counterparts.

**Mental Health Literacy**

With the importance of mental health literacy being clear, it is worth noting that recognition of some mental disorders is not high among the general public (Jorm et al., 2006) or among rural residents (Gale & Lambert, 2006). The rate of mental disorders in rural areas is comparable to urban areas; however, suicide rates (Mohatt, Adams, Bradley, & Morris, 2006), alcohol abuse and chronic illness (Wagenfeld, 2003) have been found to be higher in rural areas. To add to this risk, mental health care in rural areas is lacking, and most cases are treated by local primary care physicians (Campbell, Kears, & Patchin, 2006; Harowski, Turner, LeVine, Schank, & Leichter, 2006; Wagenfeld, 2003). Rural residents have been found to express mental health concerns somatically (Keefe, Hastrup, & Thomas, 2005) and detection of mental disorders can be higher when the patient explains symptoms that directly reflect mental health disorders (Jorm, 2000). It is important for the rural public to be literate in symptomatology to ensure their ability to properly explain to their general practitioner what they are experiencing.

Jorm et al. (1997) analyzed the mental health literacy of depression and schizophrenia in a nationally representative sample of over 2000 participants using vignette methodology. The majority of participants were able to recognize a mental disorder, but few were able to correctly label the disorder in each vignette. In a later study, 75.6% of participants in Alberta were able to correctly label depression in a case vignette (Wang et al., 2007), compared to the 67.6% in the aforementioned study. This may indicate improvement in mental health literacy over time. In another study examining the mental health literacy of anxiety disorders, 64% of the participants were able to recognize OCD, with lower recognition rates for panic disorder, general anxiety disorder, and separation anxiety disorder (Furnham & Lousley, 2013).

Rural residents also lack awareness of mental health problems and treatment options (Sawyer et al., 2006). Specifically, Kermode, Bowen, Arole, Joag, and Jorm (2009) conducted a vignette survey with participants in rural India, assessing the participants’ mental health literacy of depression and psychosis. The majority of participants recognized that the individuals in the vignettes were experiencing a mental health problem but lacked the knowledge and awareness surrounding treatment and how to respond (Kermode et al., 2009). Therefore, the authors concluded that there was a need to improve mental health literacy in this rural area (Kermode et al., 2009).
Rural areas are known to have scarce resources, high rates of poverty, less access to employment, and limited insurance coverage (Gale & Lambert, 2006; Wagenfeld, 2003); therefore, it is important to assess the mental health literacy in those areas to address possible barriers to help-seeking behaviors. Low mental health literacy is related to a lack of help-seeking behaviors (Munro, Freeman, & Law, 2004) and participants in rural Australia were significantly less likely to seek mental health treatment than those in a metropolitan area (Caldwell, Jorm, & Dear, 2004). In addition, because of the often tight-knit communities found in rural areas, people often turn to family and friends for support (Weigel & Baker, 2002). Most published research on mental health literacy in rural areas has been conducted outside of the United States; therefore, it is important to explore if these findings can be replicated in a rural area in the United States.

Further, if people do not have access to proper information regarding mental health, they might turn to the media or Internet. The link between media exposure and negative attitudes towards mental disorders has been well established (Granello & Pauley, 2000). People with mental health disorders are usually represented in a negative and often inaccurate manner which can contribute to stigmatization (Stout, Villegas, & Jennings, 2004). Specifically, the general public is commonly exposed to terminology such as “OCD” or “Obsessive Compulsive” through mainstream media (Furnham & Wincelaus, 2012). The media’s representation of Obsessive Compulsive Disorder (OCD) has been found to conflict with the true diagnostic criteria, often portraying OCD as humorous (Hoffner & Cohen, 2017) or as a result of a personality trait (Fennell & Boyd, 2014). However, recent work has indicated that the portrayal of OCD in a television series has the potential to reduce both the self and other-stigma associated with mental disorders and may improve attitudes toward help-seeking behaviors (Hoffner & Cohen, 2015; Hoffner, & Cohen, 2017).

Stigma is a barrier to seeking treatment in all communities. However, as a result of the small town culture of a rural area, residents might experience shame, embarrassment, and social stigma when they seek mental health treatment (Sawyer, Gale, & Lambert, 2006; Smith, 2003; Starr, Campbell, & Herrick, 2002). In addition, it has been suggested that rural areas and geographical locations are considered distinct cultures and culture influences mental health literacy (Furnham, Raja, & Khan, 2008; Furnham & Wong, 2007) and treatment decisions (Gale & Lambert, 2006). However, not all rural and geographical locations are the same and it is imperative to not overgeneralize from one area to the next (Sawyer et al., 2006).

### Obsessive Compulsive Disorder and Obsessive Compulsive Personality Disorder

According to the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual (DSM-5; 2013)* Obsessive Compulsive Disorder (OCD) is defined by symptoms of recurrent obsessions and/or compulsions that are time consuming or cause significant distress in one’s social, occupational, or other area of life functions. OCD is found to have a lifetime prevalence between 2-3.5% (DSM-5; 2013) and approximately 2-3 million people in the United States currently have the disorder (Ruscio, Stein, Chiu, & Kessler, 2010).
The cause of OCD is unknown; however, possible risk factors include genetics, environment risk factors, and abnormal brain structure and functioning (National Institute of Mental Health, 2016). OCD often goes unrecognized or untreated, despite the availability of efficacious treatment (Coles, Heimberg, & Weiss, 2013), with estimates of 57.3% of individuals not receiving treatment (Kohn, Saxena, Levav, & Saraceno, 2004). A study evaluating the stigma surrounding OCD found that the median length people delayed seeking treatment after onset was 47 months, with 53.8% being aware of the fact they had a problem (Belloch, Del Valle, Morillo, Carrió, & Cabedo, 2009). The most common reason for delayed treatment was the fear associated with the stigma surrounding the mental disorder (Belloch, et al, 2009).

Those with OCD who seek treatment are likely to be treated with medication, psychotherapy, or both. Cognitive behavioral therapy, a form of psychotherapy, has been found to be as effective as medication in some patients (National Institute of Mental Health, 2016). However, OCD is chronic and is thought to be one of the most debilitating mental disorders (Rachman, 1997).

The personality disorder, Obsessive Compulsive Personality Disorder (OCPD) is “a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts” (APA, 2013, p. 678). OCPD also is indicated by four (or more) of the following, inflexibility, stinginess, perfectionism, over attention to detail, excessive devotion to work, inability to discard worn or useless items, hypermorality, and inability to delegate tasks (APA, 2013). People with personality disorders are more likely to have impairments in various life domains including relationships, work, and unemployment (Morrison, 2014), often meet the criteria for another personality disorder, and have high levels of comorbidity (APA, 2013). OCPD is found to be one of the most common personality disorders with a prevalence rate around 2.5-7.9% and is found in twice as many men as women (APA, 2013). Similar to OCD, there is no known specific cause, but scholars have established various etiological factors that may contribute to this personality disorder. Genetics may play a role, as well as cultural and environmental factors, including being raised by overprotective and controlling parents (Diedrich & Voderholzer, 2015).

OCPD has not been studied to the extent that OCD has been in regard to stigma; however, research indicates that those with personality disorders experience more stigma than those with severe mental disorders (Catthoor, Feenstra, Hutsebaut, Schrijvers, & Sabbe, 2015). Another factor related to stigma that might be a barrier to help-seeking is the misconception that personality disorders are not treatable (Sheehan, Nieweglowski, & Corrigan, 2016). Finally, some promising treatments for this disorder include psychotherapy, medication, and relaxation techniques (Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997; Diaferia, Bianchi, Bianchi, Cavedini, Erzegovesi, & Bellodi, 1997).

Knowledge and Beliefs of OCD and OCPD

OCD has been found to be comorbid with OCD (Mancebo, Eisen, Grant, & Rasmussen, 2005) and some genetic models
find links between OCD and OCPD and other personality features (Bartz & Hollander, 2006). However, the relationship between OCD and OCPD has been subject of debate. One core difference between the disorders is that OCD traits are ego-dystonic and OCPD traits are ego-syntonic (Taylor, Asmundson, & Jang, 2011). This means that the obsessions and compulsions may be conflicting with the goals of someone with OCD. In contrast, in OCPD, behavior tends to be aligned with one’s goals and often provides satisfaction (Taylor et al., 2011). Therefore, due to the nature of the personality disorders, it may be useful for family members, friends, and co-workers to recognize the symptoms of OCPD.

Coles and Coleman (2010) assessed the knowledge of and beliefs about OCD in a sample of US undergraduates and found that 90.9% of participants indicated that the behaviors in the OCD vignette to be problematic; however, only one third were able to correctly identify the disorder. In another study, researchers found very low rates of recognition of OCPD compared to OCD, depression, and schizophrenia (Koutoufa & Furnham, 2014). This can become problematic to individuals who need treatment. Furnham, Abajian, and McClelland (2011) conducted a study in the UK to determine the mental health literacy of several personality disorders. The results indicated that only 41% were able to identify OCPD as a personality disorder (compared to 86% correctly identifying Borderline Personality Disorder) and only 25% could label the disorder correctly (Furnham, et al, 2011). In a more recent study on the personality disorders, participants generally were able to indicate a mental disorder was present, but failed to correctly label the disorder (Furnham & Wincelesluas, 2012). To exacerbate the confusion between OCD and OCPD, OCPD is often portrayed in the media as OCD (Furnham, Abajian, & McClelland, 2011). Therefore, the mental health literacy of the two disorders needs to be evaluated to bring awareness to each disorder and to minimize the stereotypes that can lead to popular misunderstandings. Few studies have investigated the awareness and knowledge of OCD and OCPD in the general population and no studies were found investigating the mental health literacy of OCD or OCPD in a rural area.

Current Study

The purpose of this study was to evaluate the awareness and knowledge of OCD and OCPD in a public sample of rural US citizens using a vignette methodology. The information from this study adds to the limited knowledge in published research in the US. More research in this area can lead to heightened awareness of mental health literacy and guide programs to implement in rural areas. As noted previously, rural communities have been identified as being a distinct culture with unique concerns. We proposed the following research questions: Do participants believe that the behaviors in each vignette are a cause for concern? Do participants believe that the behaviors in each vignette reflect a mental disorder? Are participants able to recognize and correctly label the mental health disorder portrayed in each vignette? If not, how do they describe what is happening in each vignette? Do the participants recommend the person in the vignette seek help and to whom do the participants recommend that the person in each vignette seek help? Do the participants recommend that the person in each vignette avoid talking about their symptoms with other people?
Even though previous research on the general populations’ knowledge and awareness of OCD and OCPD has varied, we expected that recognition and identification of mental disorders in the general population of rural residents would be low. We hypothesized that participants would label the behavior in each vignette as a cause for concern and that participants would incorrectly label the OCPD vignette as OCD.

Method

Participants

Eighty nine participants (70% female) were recruited from a rural area in the Northeast region of the United States. Participants were asked demographic questions regarding gender, age, years living in a rural area, and whether they have experience with mental health treatment or disorders, either with themselves, loved ones, or at work. The age of participants ranged from 19-86, with a mean age of 59 (SD=13.19) years old. The mean years participants have been living in a rural area was 43 years with 46% reporting previous mental health experiences.

Materials

This study used vignette methodology, a common method for examining mental health literacy (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Jorm et al., 2006) along with a questionnaire. The OCD vignette was adapted from a previous study (Pirutinsky, Rosmarin, & Pargament, 2011) and the OCPD vignette was adapted from a teaching book (Morrison, 2014). Each vignette was reviewed by two doctoral-level licensed mental health practitioners and educators. Each vignette was modified to include gender neutral naming to avoid a gender effect and both were maintained at 180-185 words. The vignettes were reviewed again and approved by the two mental health professionals and piloted by 5 undergraduate psychology students. The questionnaire was compiled from two previous studies looking at mental health literacy (Coles et al., 2013; Furnham & Lousley, 2013) and consisted of seven questions that were meant to assess each participant's mental health literacy.

Procedure

The Institutional Review Board at the college where the study took place approved the study protocol. One researcher contacted local businesses, organizations, and the school system in a small rural area (approximate population 5,860) and a single contact person from each facility was chosen to handle the recruiting. Participants were asked to take the study in a large conference room in the community setting. Participants were able to have adequate space to ensure privacy and only a limited amount of people were in the room at one time. After giving informed consent, the two vignettes were administered in a counterbalanced manner to each participant. After reading the first vignette, each participant was presented with the questionnaire. When they completed the first questionnaire, they were given the next vignette, followed by the questionnaire. Demographic questions were asked after the two questionnaires were complete. Confidentiality was maintained by giving each participant a unique identification number and the completed questionnaires were returned in a sealed folder. The study took 5-10 minutes to complete and once completed the participants were debriefed. There was no compensation for participating in this study.
Results

Analysis and Coding of Data

To address the research questions of the study, answers for each question were coded depending on the question (for example, “yes” or “no” or on a Likert-type scale). The questions: “How would you name and describe what is happening to the person in this vignette” and “Who should they go to for help?” were answered in an open-ended format. The qualitative data was analyzed independently by the two researchers using the guidelines outlined for conducting a thematic analysis by Braun and Clarke (2006). The researchers then compared notes and discussed the differences in coding until agreement was found.

Mental Health Literacy: Knowledge and Recognition

The majority of participants responded that the behaviors in both the OCD and OCPD vignette were a cause for concern (98% and 71% for OCD and OCPD, respectively). However, the majority agreed that the OCD vignette portrayed an actual mental disorder (80%) and the OCPD vignette did not (31%). In addition, 63% of the participants “correctly” labeled the OCD vignette as OCD and 0% “correctly” labeled the OCPD vignette as OCPD.

Table 1 demonstrates the results of a thematic analysis of the variety of responses given by the participants when they were asked to describe what was happening in both the OCD and OCPD vignettes. For both the vignettes, OCD was the most common response.

Mental Health Literacy: Management and Prevention

Table 2 presents the frequency of responses to the open-ended format question to who the individual in each vignette should go to for help. Participants recommended psychologist/counselor the most for each vignette.

In regards to if the participants recommended counseling or medication for each vignette, the highest percentage of participants (62%) recommended counseling in the OCPD vignette and 53% responded that both counseling and medication would be beneficial in the OCD vignette. To answer the question whether the person in each vignette should seek professional help, participants rated each vignette on a seven-point Likert-type scale of 1 (not at all) to 7 (highly recommend) that the person seek professional help. Using a paired-samples t-test, a statistically significant difference in mean scores was found between the OCD vignette (M=6.01, SD=1.37) and the OCPD vignette (M=4.05, SD=1.76), t(86)=-10.25, p=0.001 (two-tailed). Meaning that the participants recommended that the individual in the OCD vignette seek professional help more than the individual in OCPD vignette. The mean difference was 1.97 with a 95% confidence interval [2.35, 1.58]. The Cohen’s d (1.24) indicated a large effect size.

Finally, participants were asked whether the person in each vignette should avoid talking about their symptoms with other people on a seven-point Likert-type scale of 1 (not at all) to 7 (highly recommend). This question was meant to evaluate stigma by asking if the participant thought the person in the vignette should avoid talking about their symptoms with
other people. The assumption was that if it was recommended that the individual avoid talking about symptoms, this would be because of the stigma associated with mental disorders (Coles et al., 2013). A paired-samples t-test revealed a statistically significant difference in mean scores for the OCD vignette (M=2.67, SD=2.01) compared to the OCPD vignette (M=2.29, SD=1.70), \( t(86) = -2.59, p=0.01 \) (two-tailed).

Participants recommended that the individual in the OCD vignette discuss their symptoms with someone else more than the person in the OCPD vignette. The mean difference was 0.38 with a 95% confidence interval [0.67, 0.08]. The Cohen’s d (.02) indicated a small effect size.

**Discussion**

The purpose of this study was to assess the mental health literacy of OCD and OCPD in a rural area. To our knowledge this is the first study to examine the mental health literacy of OCD and OCPD in the general public in a rural area in the United States. We expected that recognition of OCD and especially OCPD would be low and that participants would find the behaviors in each vignette to be a cause for concern. We also predicted that participants would incorrectly label the OCPD vignette as OCD.

Results suggest that the majority of participants found the behaviors in both vignettes to be a cause for concern (98% and 71% for OCD and OCPD, respectively). This is promising as both vignettes presented behaviors that were maladaptive for the individual in one or more areas of their life. However, both vignettes represented a mental disorder. Although 80% of the participants identified a mental disorder in the OCD vignette, only 31% of the participants indicated that the OCPD vignette reflected a mental disorder. This might indicate that there is support that individuals with certain personality disorders, like OCPD, have been successful in life, especially in the workplace. Hence, participants might view OCPD as more of a trait (perfectionism) versus a mental disorder (Koutoufa & Furnham, 2014).

Even though the majority of the participants agreed that the behaviors in both vignettes demonstrated a cause for concern, none were able to correctly label OCPD. These findings are in line with previous research (Furnham et al., 2011; Furnham & Lousley, 2013; Koutoufa & Furnham, 2014). For the OCPD vignette, 38.2% of participants responded that the behavior represented OCD. These findings support the fact that people are not knowledgeable of the distinctions between OCD and OCPD despite high recognition of OCD (63%). Another important finding is that none of the participants were able to label the disorder of OCPD. This suggests that there is a misunderstanding of the diagnostic criteria for OCD, as well as a lack of mental health literacy of OCPD. This might indicate that people find the personality traits seen in individuals with OCPD to be the same as OCD.

Furthermore, results indicate that OCD was the most common response given for both vignettes and, similar to previous research (Koutoufa & Furnham, 2014), the next common label for OCPD was “perfectionist”. This demonstrates that participants understand one of the primary symptoms of OCPD, but do not know the specific label or may not see the behaviors as representing a mental disorder. One explanation is that the general public may use the same terminology when someone is
“obsessive” whether it is perfectionist tendencies or compulsive hand washing.

The finding that participants would recommend that the person in the OCD vignette seek professional help more than the individual in OCPD vignette is not surprising, considering that participants were able to correctly identify OCD in the OCD vignette. This demonstrates higher levels of recognition for treatment of OCD. In regards to whom the person should seek help, the findings suggest that people view outcomes of both disorders similarly. For example, 40 (51%) of the participants recommended seeing a psychologist/counselor in the OCPD vignette and 38 (46%) for the OCD vignette. This finding indicates that OCD and OCPD should be treated in the same manner. Similar to previous findings (Wang, et al., 2007), participants may not actually know what is the best treatment for each disorder. In addition, the findings might not represent poor mental health literacy, as psychotherapy is a form of treatment for both disorders. However, evidenced-based practices for OCD includes medication (Fineberg, Brown, Reghunandanan, & Pampaloni, 2012) and the findings of the current study are in line with previous research that the general public holds negative views or lacks knowledge of the effectiveness of medications for certain mental disorders (Jorm, et al., 1997).

Another finding that 16 (21%) of the participants did not recommend professional help in the OCPD vignette indicates that participants did not indicate that treatment was not necessary for a mental disorder. One promising finding of the study that is supported by previous research is that people living in rural areas may to turn toward informal networks (friends and family, clergy) or their primary care physician than their urban counterparts (Gale & Lambert, 2006). This finding highlights the importance of mental health literacy for all people.

Finally, the last question was meant to evaluate stigma. The assumption was that if it was recommended that the individual avoid talking about symptoms, this would be due to the stigma associated with mental disorders (Coles et al., 2013). Generally, the participants recommended that the individual in the OCD vignette discuss their symptoms with someone else more than the person in the OCPD vignette. However, the responses clustered around lower levels of stigma for both vignettes. This suggests higher knowledge or acceptance in areas of management and stigma, another promising finding.

Limitations and Future Research

This study examined the MHL of a sample of the population from one rural area; therefore, these findings might not be generalizable to all rural areas. Although significant results were found, as well as a clear indication that mental health literacy was not high among the sample in regard to OCPD, this study did have some limitations and needs replicated. One is the mean age of the participants was 59 years old. The most common age among participants was 62 years old, which is generalizable to the population of this small area of the United States. Previous research indicates mixed findings regarding mental health literacy and age (Coles et al., 2013; Fischer & Goldney, 2003; Furnham et al., 2011; Koutoufa & Furnham, 2014). In addition, there is a trend where younger populations are moving out of rural areas to urban areas (Campbell, Kearns, & Patchin, 2006; Wagenfeld, 2003).
Another limitation is that the study did not investigate why participants found the behaviors to reflect a mental disorder and why they labeled the disorders as they did. In addition, participants could be asked directly questions about stigma. A possible solution to this would be to administer a follow up questionnaire or interview participants to explain why they chose to answer in the manner that they did. Another avenue for further study would be to ask participants if they would actually suggest to a person with symptoms that they should seek professional treatment (Coles et al., 2013).

Another way to further this study would be to ask participants about income, socioeconomic status, levels of education, and where they receive their information regarding mental health. Knowing this information could lead to a better understanding as to what factors play a role in the mental health literacy of the rural public. Finally, the results surrounding who the individual in each vignette should go to for treatment could be clarified in future research as it is not clear if the participants understood the roles of a counselor, psychologist, psychiatrist, and primary care specialist in the treatment of OCD and OCPD.

**Implications and Conclusions**

This study revealed that the mental health literacy of OCPD among the sample of the rural public is limited and that the participants viewed both disorders similarly in regard to labeling and treatment. This lack of understanding and knowledge can have a detrimental influence on help-seeking behaviors. These findings fill a gap currently seen in mental health literacy research. There is very little research regarding the mental health literacy of OCD and OCPD, especially in a rural area in the US. This information can lead to the implementation of programs within schools, community groups, and PCP’s to bring correct information to the public and aid in the recognition and early treatment of mental health disorders. In addition, OCD causes distress to family members (Vikas, Avasthi, & Sharan, 2011); therefore, mental health literacy programs might be useful for family members or work colleagues. In addition, mental health literacy programs may promote understanding and help-seeking behaviors for a personality disorder, such as OCPD. Research suggests that educational programs informing residents of the effectiveness of treatment would be useful (Fox, Blank, Rovnyack, & Barnett, 2001) and national mental literacy initiatives in Austria have demonstrated promise (Jorm, Christensen, & Griffiths, 2006).

A final suggestion would be to address how mental disorders are represented, or misrepresented, in popular culture and everyday language. Comments such as, “that is so OCD of me” may add to the confusion and perpetuation of myths held by the general public. Therefore, educational programs that present accurate information and replace myths about mental disorders are warranted. If individuals are made aware of the fact that they are confusing the two disorders, they may take a closer look at the way other mental disorders are represented as well. By bringing awareness to this issue it may be possible to positively change the trajectory of those living and struggling with mental disorders and their family, friends, and coworkers.
References


Table 1.
*Ranking and Label of Name of What is Happening to the Person in Each Vignette*

<table>
<thead>
<tr>
<th>OCD Vignette</th>
<th>N</th>
<th>OCPD Vignette</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCD</td>
<td>54</td>
<td>OCD</td>
<td>30</td>
</tr>
<tr>
<td>Anxiety (Worried/fear)</td>
<td>13</td>
<td>Perfectionist</td>
<td>19</td>
</tr>
<tr>
<td>No answer</td>
<td>13</td>
<td>No answer</td>
<td>12</td>
</tr>
<tr>
<td>Cautious/concerned/sensitive</td>
<td>4</td>
<td>Personality</td>
<td>4</td>
</tr>
<tr>
<td>Paranoid</td>
<td>3</td>
<td>Neat (control) freak</td>
<td>4</td>
</tr>
<tr>
<td>Mentally unstable</td>
<td>2</td>
<td>Anxiety</td>
<td>3</td>
</tr>
<tr>
<td>Perfectionist</td>
<td>1</td>
<td>Careful (diligent/methodical)</td>
<td>3</td>
</tr>
<tr>
<td>Religious (need prayer)</td>
<td>1</td>
<td>Crazy (unstable/troubled)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workaholic/strong work ethic</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asperger’s/autism</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Controlling</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 2.
*Responses to Who the Person in Each Vignette Should Go To For Professional Help?*

<table>
<thead>
<tr>
<th></th>
<th>OCD (n=82)</th>
<th>OCPD (n=77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist/Counselor</td>
<td>38 (46%)</td>
<td>40 (52%)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>12 (15%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Psychiatrist and Psychologist</td>
<td>16 (20%)</td>
<td>7 (9%)</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>9 (11%)</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Parents/Family</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Friends</td>
<td>2 (3%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>N/A</td>
<td>5 (6%)</td>
<td>16 (21%)</td>
</tr>
</tbody>
</table>

Note: Total *ns* vary due to missing data