Where do we stand with OCD: Psychotherapists recognition of, and treatment recommendations for, individuals presenting with taboo intrusive thoughts

By

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Submitted in partial fulfilment of the requirements of the MA Psychotherapy at Dublin Business School, School of Arts, Dublin.

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June 2020

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Acknowledgements

- To my supervisors Siobain O'Donnell and Dr. Gráinne Donohue, thank you for your time, encouragement and enthusiasm.

- To my parents Frank and Moya, and my sister Orna, for all their support and for helping me disappear from the world to write this dissertation up.

- To all my classmates for their support and company over the past 2 years.

- To my good friend Gemma Garvey for her support and encouragement when the going got tough.

- To Dr. Kimberly Glazier Leonte for kindly allowing me to use the vignettes from her previous research on this topic.

- And finally, to my close friends Pat and Sorcha who passed away while I was writing this dissertation up. I dedicate it to both of you.

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Abbreviations used in Study

APA – American Psychiatric Association

DBT – Dynamic based therapies

EBT – First line evidence-based therapies

ERP – Exposure and Response Prevention Therapy

GAD - Generalised Anxiety Disorder

IACP - Irish Association of Counsellors and Psychotherapists

IAHIP - Irish Association of Humanistic and Integrative Psychotherapists

NICE - National Institute for Health and Care Excellence

OCD - Obsessive Compulsive Disorder

OCPD - Obsessive Compulsive Personality Disorder

PTSD - Post Traumatic Stress Disorder

Abstract

Introduction

Obsessive compulsive disorder is a prevalent mental health problem and is characterised by high levels of morbidity. It can present in a variety of ways and research suggests that taboo intrusive thoughts are less likely to be recognised as OCD in comparison to more recognisable forms. Most individuals with OCD do not receive adequate therapeutic intervention. The aim of this study was to examine psychotherapists appraisals of clients presenting with specific OCD symptoms.

Methodology

This study was a cross sectional vignette-based survey of 514 accredited psychotherapists in Ireland. Each participant was randomly assigned to a vignette describing a client with different OCD subtypes – paedophilia, aggressive, religious, homosexuality, contamination and symmetry intrusive thoughts. Participants were asked for their interpretations of the presenting symptoms, their treatment recommendations and to rate their confidence in their responses. Perceived dangerousness and willingness to work with the client were also investigated.

Results

Participants who were presented with the contamination and symmetry vignettes were significantly more likely to accurately identify OCD than those presented with the taboo intrusive thoughts vignettes. Participants also attributed greater levels of stigma to clients with taboo intrusive thoughts. Participants who correctly identified OCD were significantly more

likely to recommend an evidence-based treatment. Confidence was a poor predictor of OCD identification and evidence-based treatment recommendations.

Conclusion

The results suggest a lack of awareness of certain types of OCD presentation amongst psychotherapists in Ireland, and of beneficial therapeutic interventions for OCD. The implications of this, and possible applications of these results, are discussed in the dissertation.

Chapter 1: Introduction

Obsessive compulsive disorder (OCD) is a common mental health problem which causes significant distress and impairment for the individual concerned (Ayuso-Mateos, 2006; Grant, 2014; Fineberg et al., 2019). It is characterised by repetitive, unwanted and intrusive thoughts (obsessions) and/or repetitive behaviours or mental acts that the person feels compelled to perform (compulsions) (Kring et al., 2017; McCafferty & McDonough, 2019). Recognition and an accurate diagnosis are necessary so that individuals with OCD can receive appropriate therapeutic interventions. However, OCD is often not recognised by health and mental health professionals and there is often a long delay between the onset of symptoms and effective treatment (Fineberg et al., 2019). This can lead to a chronic outcome for the individual concerned (Grant, 2014).

OCD is a heterogenous disorder and there are a variety of ways in which it can present (Glazier & McGinn, 2015). One of these subtypes, taboo related intrusive thoughts, has been associated with poorer recognition rates and treatment outcomes in comparison to other OCD subtypes (Bruce et al., 2018). Taboo intrusive thoughts are also subject to more stigma than other forms of OCD, particularly in relation to perceived dangerousness and desire for social distance. For those whose OCD symptoms are recognised, the treatment provided or recommended is often not satisfactory. It is estimated that only 25% of those with diagnosed OCD receive adequate treatment (Stewart et al., 2019), and fewer than 10% receive evidence-based psychotherapy (EBT) (Grant, 2014). Research suggests that exposure and response prevention therapy (ERP), with or without cognitive therapy, is the most effective first line intervention for OCD (NICE, 2005; Grant, 2014).

There has been little research on OCD recognition rates amongst health care professionals. Apart from the research of Glazier et al., (2015a) there has been no research on treatment recommendations. There has been no research on recognition rates and treatment recommendations specifically with psychotherapists, who are often the first port of call for people suffering with psychological distress, and no research conducted with health care professionals in Ireland.

The aim of this research study was to examine psychotherapists interpretations of, and reactions to, a client who presents with OCD. Six vignettes referring to a client presenting with taboo intrusive thoughts (paedophilia, aggressive, religious, and homosexual), and contamination and symmetry intrusive thoughts, were presented to a sample of accredited therapists in Ireland. The study assessed the participants ability to identify OCD in their client in the vignette. It also assessed their first line of therapy recommendations for the client, and their perceptions of whether the client could potentially harm another person and their willingness to work with the client. The study assessed participants levels of confidence in their responses, and whether the gender of the client in the vignette would have any effect on OCD identification rates. The expectation was that the findings would highlight if there is a need for greater awareness and education around OCD symptomology and what constitutes effective intervention for OCD amongst psychotherapists in Ireland.

Chapter 2: Literature Review

2.1. Introduction

The chapter will begin with a definition of OCD. It will then trace the prevalence of OCD in the community and focus on the morbidity associated with OCD. It will then distinguish how OCD symptoms differ from everyday obsessions and compulsions and will highlight levels of co-morbidity with other mental health problems. Section 2 will outline the diversity of OCD symptom presentation, particularly focussing on taboo intrusive thoughts. The differences between intrusive thoughts in OCD and intrusive thoughts in other mental health disorders will also be highlighted.

Section 3 will focus on the recognition of taboo intrusive thoughts as a manifestation of OCD I comparison to the more recognisable forms of COD. It will assess recognition rates in the community, in primary care and amongst mental health professionals. Section 4 will focus on therapeutic treatments of OCD, focussing on evidence-based treatments (EBT) such as ERP and cognitive therapy. Finally, section 5 will examine the literature in relation to stigma associated with taboo intrusive thoughts, looking at perceived dangerousness and desire for social distance in particular.

2.2. Definition and characteristics of OCD

2.2.1. What is OCD?

OCD is a distressing condition characterised by repetitive, intrusive, unmanageable thoughts or impulses *(obsessions)* and/or repetitive behaviours or mental acts that the person feels

compelled to perform (*compulsions)* (Kring et al., 2017). An individual with OCD who presents to a health care professional will usually *"display or complain of either obsessions or compulsions, or both, to a degree that affects their everyday functioning or causes distress"* (Rachman & De Silva, 2009, p.3).

From a clinical perspective, OCD is determined by the following:

a. Where there is the presence of obsessions, compulsions, or both

b. Where the obsessions or compulsions are time-consuming (take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

c. The symptoms are not attributable to the physiological effects of a substance (for example, a drug of abuse, medication) or another medical condition

d. The symptoms are not better explained by the symptoms of another mental disorder.

(American Psychiatric Association, 2013)

2.2.2. Prevalence of OCD

OCD is the fourth most common psychiatric disorder in the United States (Grant, 2014). It has been identified by the World Health Organisation as a major cause of nonfatal illness globally (Ayuso-Mateos, 2006). Epidemiological studies using DSM diagnostic criteria suggest a lifetime prevalence for OCD in adults of between 1% and 3% (Fineberg et al., 2019), and a current prevalence[1] of about 1% (Overduin & Furnham, 2012). In their analysis of a sample of

[1] Estimated 12-month prevalence

2,073 people from a nationally representative survey of US adults, Ruscio et al. (2010) reported a lifetime prevalence of 2.3% and a 12-month prevalence of 1.2% for OCD.

2.2.3. Morbidity associated with OCD

OCD is associated with considerable suffering for individuals (Fineberg et al., 2019). Individuals with OCD often have a diminished quality of life which is similar in magnitude to individuals with schizophrenia (Ayuso-Mateos, 2006). It can affect quality of life in a number of ways. For example, with social, occupational and family functioning, and subjective well-being and the ability to enjoy everyday activities (Schwartzman et al., 2017). OCD is associated with more years lost to disability than Multiple Sclerosis and Parkinson's disease combined (Ayuso-Mateos, 2006). It is also associated with substantial caregiver burden and distress for the individual's family (Coles et al., 2013). OCD is also associated with increased levels of suicide and suicide attempts (De la Cruz et al., 2017).

In their analysis of data from the British Psychiatric Morbidity Study, Torres et al. (2007) reported that one in five individuals with OCD had previously been admitted as an inpatient to a mental health facility. Individuals with OCD were also three times more likely than those with other neurotic condition to have previously been admitted. They argue that while this reflects the potential severity of the disorder, it also suggests that OCD is not been recognised early enough and treated effectively by the relevant professionals (Torres et al., 2007). When an individual with OCD presents for treatment, it is often under the guise of another mental health problem. Torres et al. (2007) reported that comorbidity with other neurotic disorders, the severity of the intrusive thoughts and having suicidal thoughts are all related to seeking help for OCD, with co-morbidity being the most significant predictor.

2.2.4. How OCD differs from everyday obsessions and compulsions

It is important to clarify the use of the word obsession in the context of OCD, particularly in comparison to how the word is used in everyday life. For example, if someone is described as obsessive about football or music it generally means that they have a great interest in it and can be preoccupied by it. However, the 'obsession' generally does not cause the individual great distress, certainly not to the same level as an individual with OCD. In addition, there is generally no effort to block the thoughts or a desire to avoid the activity altogether (Rachman & De Silva, 2009).

Various forms of obsessions and compulsions are common in the general population, and most people will have experienced them at some time or another (Emerson et al., 2018; Rachman & De Silva, 2009). The difference is in their frequency, the level of distress they cause and the interference with one's life, which is linked to how the individual responds to and appraises such thoughts (Emerson et al., 2018).

2.2.5. Co-morbidity with other mental health problems

OCD has a high level of co-morbidity with other mental health problems, in particular with depression and anxiety disorders (Kring et al., 2017). Torres et al. (2007) reported that 62% of individuals (n=114) with OCD had at least one comorbid condition. These were a depressive episode (37%), generalised anxiety disorder (31%), agoraphobia or panic disorder (22%), social phobia (17%), specific phobia (15%). Mayerovotch et al. (2003) examined 172 individuals with a lifetime diagnosis of OCD and reported lifetime rates of depression (45.9%), phobia (37.8%), alcohol abuse/dependence (34.3%), generalized anxiety (31.9%), drug

abuse/dependence (20.9%), panic disorder (12.8%) and PTSD (11.6%). Research suggests that individuals with OCD who have a co-morbid disorder are more likely to present for treatment or therapy than those with OCD alone (Torres et al., 2007). They are also more likely to present in relation to their co-morbid condition, rather than the OCD symptoms themselves. This has implications for the recognition of OCD, as it often leads to its non-identification due to the presence of the co-occurring disorder (Torres et al., 2007).

2.3. Taboo intrusive thoughts

2.3.1. Heterogeneity of OCD Symptoms

One of the challenges in recognising OCD is the diversity of symptom presentation (Glazier & McGinn, 2015). There are distinct categories or subtypes within which OCD can present. Research suggests that the variance in OCD presentation is focussed across four key subtypes: (a) contamination, (b) symmetry/incompleteness, (c) responsibility for harm, and (d) intrusive taboo thoughts (Abramowitz et al., 2010; as cited in McCarty at al., 2017). Within each of these subtypes there are various ways in which OCD can manifest[2] (Schwartzman et al., 2017).

De Mathis (2011) assessed gender differences in OCD presentation. She reported that males with OCD are more likely to present with sexual, religious and aggressive symptoms, and have greater levels of comorbidity with tic and substance use disorders. Female with OCD were more likely to present with contamination and cleaning symptoms and have greater levels of comorbidity with eating and impulse-control disorders.

[2] For an outline of the different subtypes of OCD, and examples the different obsessions and compulsions within each subtype, please see appendix 1.

2.3.2. What are taboo intrusive thoughts

Taboo intrusive thoughts[3] generally consist of aggressive/violent, religious, sexual and otherwise taboo and morally repugnant obsessions (Bruce et al., 2018). They are variously reported as images, thoughts, doubts, impulses[4] (Bruce et al., 2018). Taboo intrusive thoughts are experienced as unacceptable, shameful and repugnant by the individual with OCD, and substantially interrupt ordinary preferred thinking and behaviour. The thoughts clash with the person's important values and leave them struggling with high levels of self-doubt (Rachman & De Silva, 2009). While taboo intrusive usually occur without any observable compulsions, research suggests that they are usually accompanied by covert mental compulsions or rituals. These include they avoidance of any place or situation where the thoughts tend to occur more frequently, somatic checking (for example, with sexual intrusive thoughts checking one's body for signs of sexual arousal) and reassurance seeking (Bruce et al, 2018).

2.3.3. Differentiating OCD intrusive thoughts from other mental health problems

It is important to differentiate the obsessions and compulsions which present with OCD with the symptoms of other mental health disorders (Grant et al., 2014). For example, intrusive thoughts which accompany OCD are different from the repetitive negative thoughts which accompany persistent worrying in depression, and the rumination about past events which often accompanies generalized anxiety disorder (GAD) (Hirshthrift et al., 2017)[5].

[3] Taboo intrusive thoughts are also referred to as unacceptable taboo intrusive thoughts. Taboo intrusive thoughts will be the term predominately used in this study.

[4] For the purposes of this research study the term taboo intrusive thoughts refers to the presentation of either images, impulses thoughts or doubts.

[5] For a broader profile of other mental health problems which also have features of intrusive thoughts, and how these differ from intrusive thoughts in OCD, please see Appendix 1.

Obsessive Compulsive Personality Disorder (OCPD) is characterised by personality traits such as perfectionism, excessive control (both internally and externally), elevated levels of conscientiousness and rigidity (McCafferty & McDonough, 2019). While these traits are often present in individuals with OCD, they are not the focus of the distressing symptoms. The intrusive thoughts associated with OCPD and GAD are described as ego syntonic[6], while intrusive thoughts associated with OCD are described as ego dystonic[7]. This concept of ego dystonic and ego syntonic is a key distinction between intrusive thoughts associated with OCD and intrusive thoughts associated with other mental health problems.

2.4. Recognition of taboo intrusive thoughts

2.4.1. The impact of non-recognition of taboo intrusive thoughts

OCD often goes unrecognised, and the average duration that OCD goes untreated is 10 years (Fineberg et al., 2019). OCD is commonly misdiagnosed and an accurate diagnosis is important for appropriate therapy. The evidence strongly suggests that early recognition and appropriate interventions for OCD lead to improved long-term outcomes (Fineberg et al., 2019). On the other hand, without timely and effective interventions OCD usually becomes a chronic and relapsing disorder (Grant, 2014; Fineberg et al., 2019).

[6] Ego-syntonic refers to thoughts or worries that are accepted as part of the individual's natural flow of thought, despite the fact that are related to an imagined negative event or feared consequence (McDonough and Chigwedere, 2012)

[7] Ego dystonic thoughts or worries are perceived as disconnected or alien to the individuals self-concept, while they are also related relating to an imagined negative event or feared consequence (McDonough and Chigwedere, 2012)

Taboo intrusive thoughts are common in people with OCD at any age, yet often remain unrecognised, sometimes for many years (National Institute for Health and Care Excellence (NICE), 2005). Taboo intrusive thoughts have been associated with poorer recognition rates and poorer treatment outcomes in comparison with other OCD subtypes (Bruce et al., 2018). For example, fears of sexually harming children[8] are relatively common amongst individuals with OCD (Bruce et al, 2018; Williams & Farris, 2011), yet such symptoms are mostly unrecognized and often misdiagnosed by health professionals. The absence of observable compulsions can make taboo intrusive thoughts difficult to detect. Because of their highly stigmatized content, individuals tend to conceal their experiences of such thoughts. Therefore, actual prevalence rates are likely to be higher than generally indicated (Bruce et al, 2018). Taboo intrusive thoughts are also sometimes misinterpreted as indicating risk (NICE, 2005; Bruce et al, 2018).

2.4.2. Public recognition of taboo intrusive thoughts

Individuals with taboo intrusive thoughts, and indeed the general public, often do not realise that certain types of intrusive thoughts (for example, aggressive, religious and sexual thoughts) are consistent with OCD (Grant, 2014). In a vignette study with adolescents in Spain, Garcia-Soriano and Roncero (2017) found that a high proportion of adolescents correctly identified ordering symptoms as OCD (84.3%), but a low proportion correctly identified aggressive intrusive thoughts as OCD (23.7%). The aggressive intrusive thoughts vignette was more frequently recognised as schizophrenia (34.3%) or depression (28.4%) (Garcia-Soriano & Roncero, 2017).

[8] These types of intrusive thoughts are usually referred to as 'sexual obsessions about children' of 'paedophilia intrusive thoughts'. Paedophilia intrusive thoughts will be the term used predominately in this study.

McCarty et al. (2017) presented vignettes of four OCD subtypes to 730 adults via an online survey in the United States. They reported that symmetry and contamination dimensions were significantly more likely to be recognised as OCD (84.5% and 76.1% respectively), than responsibility for harm or taboo dimensions (sexual intrusive thoughts) (36.9% and 30.9%, respectively). Stewart et al. (2019) surveyed 806 people in New York State assessing their knowledge of OCD. Most participants described OCD either in relation to overt compulsions or perfectionism.

2.4.3. Recognition of taboo intrusive thoughts in primary care

OCD is often not recognised in both primary care and psychiatric settings (Grant, 2014). Glazier et al. (2015a) assessed the capacity of 208 primary care physicians to correctly diagnose intrusive thoughts. Vignettes relating to aggression, fear of saying things, homosexuality and paedophilia were misidentified in the majority of cases (between 70-85%), in comparison to vignettes relating to somatic concerns, religion and contamination (between 32-40%), and symmetry (3.7%). Of particular note in this study was the participants who correctly identified their vignette as OCD were significantly more likely to recommend an empirically supported first-line treatment (Glazier et al, 2015).

2.4.4. Recognition of taboo intrusive thoughts amongst mental health professionals

Glazier et al. (2013) assessed rates of OCD symptom misidentification by mental health professionals. Three hundred and sixty-six mental members of the American Psychological Association completed a vignette-based survey assessing their ability to identify four types of

taboo intrusive thoughts versus a contamination vignette. Misidentification rates were significantly higher for taboo intrusive thoughts (homosexuality, 77.0%; paedophilia, 42.9%; aggression, 31.5%; and religion, 28.8%) vs the contamination vignette (15.8%).

Glazier and McGinn (2015) examined OCD awareness amongst 82 clinical and counselling psychology doctoral students. Participants were significantly more likely to report 'no awareness' or 'very little awareness' when presented with non-contamination and non-symmetry obsessions[9] (17.1%-36.0%), compared to contamination or symmetry obsessions (1.3%-3.9%). Participants were also significantly more likely to misdiagnose the non-contamination and symmetry obsessions (Glazier & McGinn, 2015).

2.5. Psychotherapeutic interventions for OCD

2.5.1. Implications of inadequate therapeutic intervention

It is estimated that only 25% of those with diagnosed OCD receive adequate treatment (Stewart et al., 2019). Fewer than 10% receive evidence-based psychotherapy (Grant, 2014). Without appropriate treatment remission rates for OCD tend to be low (approx. 20%), with appropriate treatment they are substantially higher (Mancebo et al, 2006). By missing out on timely and effective treatment individuals with OCD are likely to endure a chronic and relapsing disorder (Fineberg et al., 2019).

[9] Obsessions related to fear of saying things, aggression, paedophilia, religion and somatic concerns.

Torres et al. (2007) reported that 40% of those with OCD in their study were receiving some kind of intervention, but less than 10% had seen a mental health professional in the previous year. Twenty per cent of their sample were receiving medication only, 5% were receiving counselling or psychotherapy only, and 15% were receiving both medication and counselling or psychotherapy. Of these 20% who were receiving counselling or psychotherapy, only 5% were receiving an evidence-based intervention (Torres et al., 2007). Individuals with OCD who also had a comorbid mental health problem were significantly more likely to be receiving some form of intervention than those with no comorbid issue (Torres et al., 2007).

2.5.2. Efficacy of psychotherapeutic interventions for OCD

There is strong support for the efficacy of ERP, and in some cases cognitive therapy, for the treatment of OCD (Grant, 2014; Hirschtritt et al., 2017; Olatunji et al., 2013; Ost et al., 2015). ERP aims at the gradual habituation to the distressing thoughts and the prevention of the habituated response (Knoop et al., 2013). Cognitive therapy looks at the irrational and dysfunctional beliefs relating to the meaning and significance of the intrusive thoughts (Knoop et al., 2013). ERP is supported by a larger body of empirical data and is therefore recommended as the first-line psychotherapy treatment[10] for OCD (NICE, 2005; Grant, 2014). Research also suggests that ERP has an equal or greater overall effect than medication[11] (Ost et al., 2015, Hirschtrit et al, 2017).

[10] First line treatment in this case refers to the therapies that can have the greatest impact initially in terms of symptom and distress reduction

[11] Anti-depressants (SSRI's, SNRI's) are the recommended first line forms of medication for ODC (Grant, 2014). However, the focus of this study is on psychotherapies, and therefore the effectiveness of medication, or medication as a first line treatment, is not considered.

2.5.3. Evidence based therapies: ERP

The aim of ERP is for the gradual habituation to the anxiety provoking stimulus (Bruce et al., 2018). The client is exposed to the feared stimuli (exposure) and tries to refrain from performing their compulsions (response prevention) (Bruce et al., 2018). The exposure usually takes place in a controlled environment (for example, an individual with contamination obsessions and compulsions touching objects in a public toilet, or alternatively through imagined exposure to the feared stimuli). The client is exposed in a gradual way, starting off with situations which provoke moderate levels of anxiety and then moving to more severe anxiety provoking situations as tolerance increases. The client is challenged to face the situation without reverting to their compulsion. In the case of intrusive thoughts, this includes not engaging in ritualising, assurance seeking or avoidance. Over time the goal is to weaken the connection between the feared stimuli and the distress in order to reduce the strength of the intrusive thoughts and the distress that accompany them (Hirschtritt et al, 2017).

2.5.4. Evidence based therapies: Cognitive therapy

ERP can be combined with cognitive techniques which target the irrational and dysfunctional beliefs relating to the obsessive thoughts (American Psychiatric Association (APA), 2007; Bruce et al., 2018). Dysfunctional beliefs in OCD include excessive feelings of responsibility and guilt (for example, responsibility for unwanted events), superstition and magical thinking, overestimations of the probability of feared events, the assumption that thoughts are morally equivalent to actions or inevitably lead to action (thought-action fusion), perfectionism and a strong need for certainty and control (Challacombe et al., 2011; Knoop et al., 2013; Veale & Willson, 2005).

Cognitive therapy has demonstrated its short and long-term efficacy in the treatment of OCD (Hirschtritt et al., 2017). While many experts believe that combining ERP and cognitive therapy is likely to be the most effective approach (APA, 2007), there is no specific research which suggests that the addition of cognitive therapy to ERP improves outcomes (Hirschtritt et al., 2017). McKay et al. (2017) suggest that the provision of cognitive therapy targeting specific symptom-related difficulties may improve tolerance of distress, symptom-related dysfunctional beliefs and adherence to treatment. Cognitive therapy may also be the preferred form of therapy for individuals who are unable to tolerate the exposure aspects of ERP (Hirschtritt et al, 2017).

While research has shown that ERP, with or without cognitive therapy, can be effective with OCD, it is important to note that there is some variability in terms of the outcomes of different trials. That is, different trials have produced different results (Bruce et al., 2018). There is also variability with individual responses. That is, ERP works well for some people but not for others. This is mostly due to high attrition rates or a limited response to the therapy (Bruce et al., 2018)

McDonough and Chigwedere (2012) argue that ERP can at times be more beneficial when there are clear overt compulsions present (for example, ordering and washing), and that with taboo intrusive thoughts the exposure element can sometimes be hampered by shame and cognitive avoidance. In such cases, the utilisation of techniques from cognitive therapy, including specifically working with cognitive processes such as thought–action–fusion and responsibility beliefs, can be useful in overcoming these challenges (McDonough & Chigwedere, 2012).

2.5.5. Other therapies: Psychodynamic therapies

There are no controlled studies that demonstrate the effectiveness of psychodynamic psychotherapy or psychoanalysis in dealing with the core symptoms of OCD (APA, 2007). Symptoms of OCD are usually strong impediments to interpretive and object relations work (Gold & Stricker, 2001). Psychodynamic psychotherapy can potentially help individuals who are resistant to treatment overcome this by examining possible unconscious rationales for wanting to remain as they are (for example, receiving personal attention or an escape from responsibility or unpleasant situations), and by examining the interpersonal implications of their symptoms (APA, 2007). It can also potentially help illuminate the underlying resistances to the explorative work of ERP (Stricker & Gold, 1996).

Insight or interpretive modes of psychotherapy can potentially be of benefit at some stage in a client's recovery from OCD (APA, 2007). Stricker and Gold (2001) give an example of how this might work. They proposed a three-tiered integrative model for OCD. Specific behavioural problems are located in Tier 1; maladaptive conscious cognitions and emotions are located in Tier 2; and unconscious conflicts, motives and object representations are located in Tier 3, while the model is underpinned by a humanistic perspective (Gold & Stricker, 2001). Behavioural and cognitive concepts and techniques are located in the first two tiers of the model because interpretive or insight methods of psychotherapy are limited in their impact upon many of the symptoms and character traits that present in obsessive-compulsive clients (Gold & Stricker, 2001).

2.6. Stigma and taboo intrusive thoughts

Research suggests that stigma is a major barrier for individuals seeking treatment for taboo intrusive thoughts (Glazier et al., 2015b). The impact of public perceptions of taboo intrusive thoughts is very relevant here and will now be explored.

The most researched aspects of stigma and mental health problems are perceptions of dangerousness and the desire for social distance from the individual (Jorm et al., 2012). These concepts were initially investigated by Link et al. (1999), who presented vignettes of four mental health problems (not including OCD) to the general public. They reported a strong association between mental health symptoms and the perceived dangerousness of the individual, and the desire for social distance from the individual. Sowislo et al. (2017) reported that perceived dangerousness for psychiatric symptoms is more relevant when the character presented in the vignettes is male rather than female.

2.6.1. Public perceptions of taboo intrusive thoughts

Symptom subtype is an important aspect of the social perception of OCD (McCarty et al., 2017). In an online survey on recognition and perceptions of OCD, McCarty et al. (2017) reported that participants who were presented with an taboo intrusive thought vignette perceived significantly higher levels of stigma for the individual in their vignette. Participants who correctly identified their vignette as OCD reported lower levels of fear and wanted significantly less social distance from the individual than those who did not identify OCD. Simonds & Thorpe (2003) presented vignettes of 3 different types of OCD presentation – a

compulsive washer, a compulsive checker, and a person with violent thoughts. They reported that the person with violent thoughts was perceived more negatively than the other two.

Corcoran and Woody (2008) presented 3 vignette types (aggressive, sexual and blasphemous) to 122 mostly undergraduate psychology students. Each participant was also assigned to either a 'self' group (where the participant themselves is experiencing the intrusive thoughts), or to an 'other' group (where a close friend confides with the participant about their intrusive thoughts). Participants were asked about the levels of personal significance their vignette had for them (the degree to which 'self' or 'other' is dangerous, untrustworthy, bad or wicked, weird, unstable etc.) Overall, participants rated the vignettes generally low in personal significance, with no significant overall differences between 'self' and' other'. There were significant effects across vignette type however, with the aggressive vignette more personally significant than the sexual vignette, which in turn was more personally significant than the blasphemous vignette. This relationship was stronger for the 'other' condition, although the relationship was 'robust' across both conditions.

Cathey and Wetterneck (2013) examined the relationship between stigma and the disclosure of intrusive thoughts about sexual themes. One hundred and fifty seven adult participants aged between 18-60 years of age, who were enrolled in some type of psychology course in a mid-sized university in Texas, were recruited for the study. Each participant was presented with a vignette where either a friend or a significant other had disclosed to them that they were having either intrusive thoughts about sexual themes or intrusive thoughts relating to contamination. Participants were asked about their perceptions of the individual based on four themes: social

rejection, perception of psychological problem, general concern, and disclosure (willingness to self-disclose similar content).

Participants rated the sexually related intrusive thoughts as significantly more stigmatizing than the contamination related intrusive thoughts, with the main effects in the social rejection and disclosure themes, whereby participants reported that they would be significantly more willing to disclose a contamination related intrusive thought of their own than a sexually related intrusive thought. Also, disclosure by a significant other was met by significantly more disapproval than a by a friend (Cathey & Wetterneck, 2013).

Durna et al. (2019) conducted a study assessing desire for social distance towards individuals from 5 OCD vignettes (contamination, checking, aggressive, religious and sexual themes), and a paranoid schizophrenia vignette. Six hundred and twenty one adults form a region in Turkey, none of whom worked in the area of mental health, participated in the study. There were no differences between the aggressive, sexual and schizophrenia vignettes in terms of desire for social distance. However, the desire for social distance was higher for these vignettes than for the religious vignette, and in particular the contamination and checking vignettes.

Glazier et al. (2015b) reported that the most frequent barriers for not seeking help are the being ashamed of my problems (75%), ashamed of needing help (65.9%), worried what others would think if they knew they were receiving treatment (65.9%), wanting to do it on their own (73.8%), being unsure where to go/who to see (66.5%), and being uncomfortable speaking with a mental health professional (48.2%). Perceived barriers were significantly higher for individuals with taboo intrusive thoughts than more recognisable forms of OCD.

The reluctance to talk about intrusive thoughts can also be related to a fear of being considered insane or dangerous and that one will be admitted to a psychiatric facility or even arrested (Torres et al, 2007).

2.7 Conclusion

This literature review has described the main characteristics of OCD, in particular taboo intrusive thoughts. It has highlighted the phenomenon of the misidentification of taboo intrusive thoughts in a variety of settings. It has also highlighted the implications of this. It has highlighted that few individuals with taboo intrusive thoughts are provided with EBT's, what these EBT's are and the implications of this. Finally, this literature review has highlighted the existence and impact of stigma in relation to taboo intrusive thoughts.

Therefore, this research study will now assess recognition rates for OCD amongst a cohort of psychotherapists in Ireland. It will also assess the recommended treatments by this cohort for individuals presenting with OCD, and whether there is a relationship between OCD recognition and the recommendation of an EBT. The potential stigmatisation of the client will also be accounted for, with questions relating to the clients potential to harm another other person and the willingness to work with the client. The next section of this dissertation will outline the methodology used in asking these important questions amongst a cohort of psychotherapists in Ireland.

Chapter 3: Methodology

3.1. Introduction

This chapter will focus on the methodology used in the study. It will describe the study design, will outline the method of data collection and will describe the sample used in the study. It will then highlight the data analysis procedures used in the study, both the statistical tests used and the results of a power analysis which outlined the number of participants necessary to generate adequate statistical power for the study. The ethical considerations in the study will then be discussed. Finally, the specific hypotheses and areas for exploration in the study will be put forward.

3.2. Study Design

In this cross-sectional quantitative research study, a sample of accredited psychotherapists in Ireland were invited to complete a vignette-based questionnaire. The aim of the questionnaire was to assess psychotherapists interpretations and reactions to a client who presented at their practice with specific OCD symptoms. The design used in this study has been used in previous studies analysing recognition of OCD symptoms (Glazier et al., 2013; Glazier & McGinn, 2015; Glazier et al., 2015a; Garcia-Soriano & Roncero, 2017; McCarty et al., 2017; Stewart et al., 2019).

Six subtypes of OCD were used in the development of the vignettes for the study – paedophilia intrusive thoughts, homosexual intrusive thoughts, aggressive intrusive thoughts, religious intrusive thoughts, contamination intrusive thoughts and symmetry intrusive thoughts. The

study also wanted to assess whether there are any differences in respondents' reactions to their client based on the clients gender. Therefore, a male and a female version of each vignette was developed, so 12 vignettes[12] in total were used in the study (6 subtypes x male/female). The demographic information, with the exception of gender, was kept the same across all vignettes, in order to reduce the possibility of content bias.

The vignettes used in this study are a replication of those used by Glazier et al. (2015a). Permission was sought and granted to use these vignettes. Glazier et al. (2015a) conduced a comprehensive validation[13] process for each vignette, which involved 28 mental health professionals. Each vignette was rated by at least 5 mental health professionals to ascertain if the vignette was accurately representing the intended OCD subtype. For a more comprehensive outline of the validation process please see Glazier et al. (2015a, p. 762).

3.3. Data Collection

The questionnaire[14] was developed and disseminated using survey monkey software. At the beginning of the questionnaire the participants were asked to provide demographic information. The demographic variables were gender, length of time practicing as an accredited psychotherapist, level of academic qualification (degree, masters and so forth), and modality of psychotherapy qualification (humanistic, gestalt and so forth).

[12] To view all 12 vignettes please see Appendix 3: Vignettes

[13] The concept of validity reflects the accuracy with which the measures used measures the subject being studied and subsequently the accuracy with which the findings reflect the phenomenon being studied. To put it more simply, do the vignettes measure what they are supposed to measure.

[14] To see the full version of the questionnaire, please see appendix 2.

Following this the participants were presented with one of the 12 vignettes. The vignettes were randomly assigned to each participant. This was done through the survey monkey software. After reading the vignette the participants were asked to give their opinion on whether any of 21 mental health problems (both clinical and non-clinical) apply to the client. Participants could select up to 3 issues. Participants were considered to have correctly identified OCD regardless of whether they had also selected a 2nd or 3rd issue. The order of presentation of the mental health problems was randomised to ensure that there were no response order biases. The participants were then asked to rank their levels of confidence in answering this question on a 5-point Likert Scale, ranging from 'not at all confident' to very confident'.

Following this the participants were asked to select which type of therapy they felt would be the most beneficial as the first line of therapy for the client, from a list of 20 options. Participants could select up to 3 types of therapy. The order of presentation of the therapies was randomised to ensure that there were no response order biases. Once again, the participants were then asked to rank their levels of confidence in answering this question on a 5-point Likert Scale, ranging from 'not at all confident' to very confident'.

Participants were then asked whether they believed the client in their vignette could harm another person. To do this, participants were presented with a 7-point Likert scale ranging from 'very likely' to 'highly unlikely'. The last question in the survey asked respondents whether they would be willing to work with the client presented in their vignette. Participants were asked to rate their willingness to work with the client on a 7-point Likert scale ranging from 'very unlikely' to 'highly likely'. Both the potential for harm and willingness to work with

questions were developed to assess two of the most common forms of stigma attribution, (1) fear and dangerousness, and (2) help and interact, as outlined by Brown (2008).

The survey was piloted on a group of 10 individuals before data collection began, and the questionnaire was adjusted according to the feedback given. Data collection took place between the 31st of March 2020 and the 19th of May 2020. An initial email was sent, and the recipient was invited to participate in the study. In this email the study author introduced himself and the context of the study was explained (a psychotherapy master's dissertation at Dublin Business School). As the participants had to be kept blind to the rationale of the study, the survey was simply called 'psychotherapy research study'. The recipients were informed that their participation was anonymous and that they were free to withdraw at any time. A link to the survey was provided with the e-mail. Eighteen days after the first e-mail was sent, a reminder e-mail was sent.

3.4. Study sample

A purposive sampling strategy was used in the study. The study sample consisted specifically of psychotherapists in Ireland who were fully accredited with either the Irish Association of Humanistic and Integrative Psychotherapists (IAHIP) and the Irish Association of Counsellors and Psychotherapists (IACP). All fully accredited therapists from both these organisations who practiced in the 32 counties (the Republic and Northern Ireland) were eligible to participate in the study. Names and contact email of psychotherapists were sourced from both the IAHIP and IACP websites and from this a database of contacts[15] was created. This led to a sample of 2,302

[15] Not all therapists provided a contact email address on the respective websites. Only those who provided an email address were included in the study. From a population sample of approximately 3,400 therapists, 1,100 did not provide an email address.

accredited therapists. Accordingly, 2,302 psychotherapists were e-mailed an invitation to participate in the study. From this there were 565 responses in total. Of these, 52 (9.2%) only partially completed the questionnaire and so were excluded from the study. This left 515 complete responses. One of these respondents was excluded from the study because they were not yet fully accredited as a psychotherapist, which left a total of 514 eligible responses for the analyses and an overall response rate of 22.5%. The average time for completing the questionnaire was 5 minutes. Table 1 outlines the number of eligible responses per vignette type, for both the female and male versions and the total (male + female).

Table 1. Number of valid responses for each Vignette Type (n=514)

Vignette Type	N (overall %)
Paedophile Male	**42** (8.2%)
Paedophile Female	**41** (8.0%)
Total	**83** (16.1%)
Aggressive Male	**43** (8.4%)
Aggressive Female	**43** (8.4%)
Total	**86** (16.7%)
Religious Male	**38** (7.4%)
Religious Female	**41** (8.0%)
Total	**79** (15.4%)
Contamination Male	**49** (9.5%)
Contamination Female	**48** (9.3%)
Total	**97** (18.9%)
Symmetry Male	**49** (9.5%)
Symmetry Female	**38** (7.4%)
Total	**87** (16.9%)
Homosexual Male	**44** (8.6%)
Homosexual Female	**38** (7.4%)
Total	**82** (16.0%)

3.5. Data analysis procedures

3.5.1. Statistical tests used in study

SPSS (IBM) statistical software was used to analyse the data. All analyses were 2 tailed, and statistical significance was determined by $\alpha = .05$.

Descriptive statistics (number and %) were used to describe the study sample in terms of the demographic variables.

Descriptive statistics (number and %) were also used to describe and summarise the responses for each of the six questions on the vignette. Responses across all vignette types were also described for question six*:* 'In your opinion, do any of the following apply to the client'?, and question eight: 'Based on the Vignette, which form of therapy do you feel would be the most beneficial as the first line of therapy for the client'?

A chi square test of independence ($\chi 2$) was used to compare the rates of OCD identification against the gender of client. $\chi 2$ analyses was also used to compare total rates of OCD identification across the vignette subtypes. If the $\chi 2$ statistic was significant, a binary logistic regression was used to determine the odds of correctly identifying OCD in the taboo vignettes versus a control condition of the contamination and symmetry vignette types combined.

$\chi 2$ analyses was used to compare whether there were any significant differences in each of the vignette subtypes for the recommendation of an EBT. $\chi 2$ was used also to assess if there were any significant differences between OCD identification and the recommendation of an EBT.

Mann-Whitney (U) or Kruskall Wallis (H) statistical tests were used to assess respondent's levels of confidence relating to question six and eight, depending on the number of levels in the independent variable.

Mann-Whitney (U) or Kruskall Wallis (H) tests were also used to assess respondent's opinions on how likely is it that the client could harm another person and how willing they would be to work with the client. If significant differences were found, an ordinal logistic regression was used to compare responses between the taboo vignettes and the contamination/symmetry vignettes.

3.5.2 Power analysis

Adequate statistical power means that the study is capable of detecting significant relationships among the measures of interest (Cohen, 1992). Power analyses generate the number of responses that are needed in the study overall, and per statistical test, to ensure adequate statistical power in the study (Sauermann & Roach, 2013).

A power analysis based on the sample size in this study (2,302), with a 95% confidence interval and a 5% margin of error, estimated that between 322 and 357 responses were necessary for adequate statistical power (Cohen, 1992). The study had 514 responses.

The following number of responses for each statistical test are based on estimates provided by Cohen (1992).

- For $\chi 2$ tests, a sample size of up to 143 (for 5 degrees of freedom or less) was required for adequate statistical power[16]
- For the logistic regressions, all of which had 5 predictors (4 taboo intrusive thoughts vignettes and contamination/symmetry vignette), a sample size of 91 was required for adequate statistical power.
- For the Mann-Whitney tests, 64 people were required per level of independent variable, therefore a sample size of 128 was required for adequate statistical power.

3.6. Ethical considerations

The following ethical principles were taken into account in the study:

- *Voluntary participation:* Participants were invited to participate in the survey through email and were not coerced in any way into participating. Participants were free to withdraw at any time.
- *Informed consent:* As participants had to be blind to the actual objective of the study, they were told that it was a research study investigating psychotherapists responses to a client with distressing psychological symptoms. The role of the researcher was outlined clearly – an M.A. in psychotherapy student at Dublin Business School completing his dissertation.

[16] All estimated sample sizes given are based on a medium effect size and p = 0.05

- *Anonymity:* Participants were assured in the initial email and in the survey introduction that their responses were anonymous, in that no details were attached with any of the survey responses.
- *Confidentiality:* As all responses were anonymous, confidentiality was not an issue in the study.

3.7. Hypotheses and areas for exploration

Based on the research outlined in this literature review, the following hypotheses will be tested in the results section.

Hypothesis 1. Participants will be significantly less likely to identify the taboo intrusive thoughts vignettes as OCD, in comparison to the contamination and symmetry vignettes.

Hypothesis 2. Participants who identify their vignette as OCD will be significantly more likely to recommend an evidence based first line of therapy for their clients.

Hypothesis 3. Participants who are presented with the paedophilia and aggressive vignettes will be significantly more likely to feel that their client could potentially harm another person, and significantly less likely to be willing to work with their client, in comparison to the contamination and symmetry vignettes.

The following questions will also be explored:

Exploration 1: Whether there are any differences in OCD identification rates relating to the gender of the client in the vignette, both overall and within each vignette subtype.

Exploration 2: What is the relationship between OCD identification and therapy recommendations, and participants confidence levels in their responses.

Exploration 3: Whether there are any differences across demographic variables (gender, level of experience, level of qualification and qualification type) in relation to the following variables - OCD identification, therapy recommendation, confidence, possibility of harm and willingness to work with.

The study will now proceed to the results section.

Chapter 4: Results

4.1. Introduction

This chapter will start with a description of the study sample. Following this, the overall responses to question 6 on OCD Identification will be summarised and the overall OCD identification rate will be presented. The question of whether the gender of the presenting client had a difference on OCD identification rates will then be examined. Following this, the question of whether there is a significant difference in OCD identification rates between the taboo vignettes and the contamination and symmetry vignettes (hypothesis 1) will be examined. The participants confidence in their responses to question 6 will also be investigated.

The responses to question 8 on therapy recommendations will then be summarised. The frequency of EBT recommendations will be highlighted and participants confidence in their responses to question 8 will be investigated. The association between OCD identification and the recommendation of an EBT will then be investigated (hypothesis 2). The question of the clients potential to harm someone and the participants willingness to work with the client will then be examined (hypothesis 3). Finally, the effect of demographic variables on the data will be investigated.

4.2. Description of study sample

Table 2 provides a description of the participants in terms of gender, length of time practicing as an accredited therapist (experience), level of qualification and theoretical orientation of qualification. Almost 3 times as many females responded to the survey in comparison to males.

There was a reasonably good spread of participants across the three levels of experience, with 10+ years being the most frequent response (44% of sample). Most participants (83.5%) had either a degree, post graduate diploma or masters in psychotherapy. The primary theoretical orientation of participants training was humanistic/integrative (77%), with 'other' (7.4%) and psychodynamic (6.8%) being the next most frequent responses.

Table 2. Description of the study sample (n=514)

Characteristic	N (%)
Gender	
Female	378 ***(73.5%)***
Male	134 ***(26.1%)***
Other	2 ***(.4%)***
Length practicing as an accredited psychotherapist	
0-5 years	139 ***(27%)***
5-10 years	149 ***(29%)***
10+ years	226 ***(44%)***
Level of qualification	
Certificate	3 **(.6%)**
Diploma	72 ***(14%)***
Degree	112 ***(21.8%)***
Postgraduate Diploma	133 **(25.9%)**
Masters	184 **(35.8%)**
PhD	8 **(1.6%)**
Other	2 **(.4%)**
Theoretical orientation of training	
Humanistic/Integrative	396 **(77.0%)**
Other	38 **(7.4%)**
Psychodynamic	35 **(6.8%)**
Gestalt	16 **(3.1%)**
Cognitive Behavioural	12 **(2.3%)**
Body-Oriented	5 **(1.0%)**
Couples Therapy	5 **(1.0%)**
Existential	4 **(.8%)**
Psychoanalytical	2 **(.4%)**
Family Therapy	1 **(.2%)**

In relation to the level of qualification variable, it was decided to omit 'certificate' (.6% of participants) and 'PhD' (1.6% of participants) from any further analysis as the number of participants were too small to have any meaningful impact on the results. Also, as the majority of participants (77.0%) selected 'humanistic/integrative' as the theoretical orientation of their training (77.0%), it was decided to omit this variable from any further analysis, as the spread of responses across the variable was insufficient.

4.3. Responses to question 6: OCD identification

4.3.1. Frequency of responses overall

Table 3 shows the total responses to question six, *"In your opinion, do any of the following apply to the client"?* The participants were presented with 21 potential mental health problems. The total number of options selected by participants was 911, which gives an average of 1.78 per respondent. OCD was the most frequent choice (n=243), followed by generalised anxiety disorder (GAD) (n=165) and post-traumatic stress disorder (PTSD) (n=62). Thirty-three participants selected 'none of these apply', while 91 participants selected 'other'[17].

Table 4 shows the response dynamic across the 6 vignette subtypes for question 6, "In your opinion, do any of the following apply to the client"? *The top 3 choices for each vignette type are highlighted. For the contamination, symmetry and paedophilia vignettes, OCD was the*

[17] Of those who selected other, 9 made some reference to intrusive thoughts or obsessions. As it was not clear whether they meant intrusive thoughts or obsessions in relation to OCD, it was decided not to count them as OCD responses.

Table 3. Question 6: In your opinion, do any of the following apply to the client? (number of responses overall = 911)

Mental health problems	Number times selected	Mental health problems	Number times selected
Anger management issues	4	***Paedophilia***	5
Bipolar disorder	1	***Panic attacks***	14
Borderline personality disorder	13	***Paranoid personality disorder***	14
Depression	30	***Perfectionism***	44
Generalized anxiety disorder	165	***Post-traumatic stress disorder***	62
Impulse control disorder	31	***Psychosis***	6
Narcissistic personality disorder	1	***Scrupulosity***	49
None of these apply	33	***Sex addiction***	1
Obsessive compulsive disorder	243	***Social anxiety disorder***	33
Obsessive compulsive personality disorder	54	***Specific phobia***	17
Other (please specify)	91		

most frequent response. For the aggressive and homosexuality vignettes, GAD was the most frequent response. For the religious vignettes there was an equal response rate between OCD and GAD. When the responses for the 4 taboo intrusive thoughts vignettes were combined, there were more GAD responses overall (n=114) than OCD (n=108). It is interesting to note the 3rd most frequent choice for each vignette type. They are different across all 6 vignettes and in most cases are specifically related to the symptoms presented in the vignette. As an example, the 3rd most frequent choice for the symmetry vignettes was perfectionism (n=25). Finally, the average number of options selected is lower for the aggressive vignettes (n=1.65), and particularly the homosexuality vignettes (n=1.44), compared to the rest of the vignette subtypes. For a full overview of responses for each vignette subtype for question 6, please see Appendix 5.

Table 4. The number of responses and most popular responses per vignette type to Q6.

	Paedo (n=83)	Aggress (n=86)	Religious (n=79)	Contam (n=97)	Symm (n=87)	Homosex (n=82)
Total number selected	151	142	147	177	168	118
Average number selected	1.82	1.65	1.86	1.82	1.93	1.44
Most frequent choice	30 *OCD*	29 *GAD*	29 *OCD*	75 *OCD*	60 *OCD*	27 *GAD*
2nd most frequent choice	29 GAD	23 *OCD*	29 *GAD*	22 *GAD*	29 *GAD*	26 *OCD*
3rd most frequent choice	20 *PTSD*	11 *impulse control disorder*	*29 Scrupulosity*	20 *Specific Phobia*	25 *Perfectionism*	11 *none of these apply*

4.3.2. Overall OCD identification rates

Figure 1 shows total OCD recognition for all participants (n=514). Overall, 47.3% of participants identified the client's presentation as OCD, while 52.7% did not.

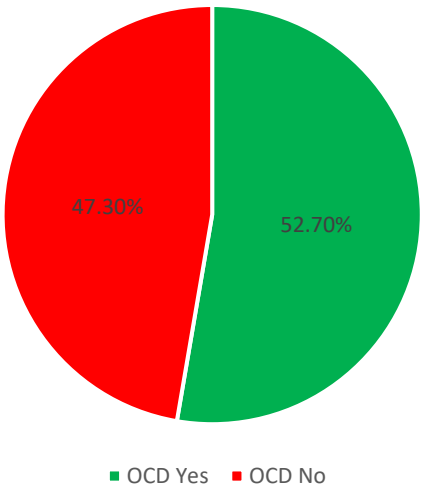

Figure 1. Total OCD recognition rates for all participants (n=514)

4.3.3. OCD identification for gender of presenting client

Table 5 shows OCD identification rates for each of the 12 vignettes. The particular purpose of this table is to compare recognition rates across gender for each of the vignette subtypes. For example, is there any significant difference in recognition rates between the male contamination vignette and the female contamination vignette. The statistical analyses presented in table 5 shows that there are no significant differences in recognition rates for client gender across any of the vignette subtypes. In fact, the recognition rates are quite similar for both genders across all vignette subtypes. Therefore, it was decided to combine both male and female responses for each vignette type (n=6) for the remainder of the analysis in this study.

Table 5. OCD Identification Rates x Gender of Vignette Subject (n=514)

Vignette Type	Male version	Female version	Pearson's χ^2	DF	P value
Contamination (n=75)	38 **(50.7%)**	37 **(49.3%)**	.003	1	.956
Symmetry (n=60)	36 **(60.0%)**	24 **(40.0%)**	1.063	1	.302
Paedophilia (n=30)	16 **(53.3%)**	14 **(46.7%)**	.140	1	.708
Religious (n=29)	15 **(51.7%)**	14 **(48.3.%)**	.241	1	.624
Homosexuality (n=26)	14 **(31.8%)**	12 **(31.6%)**	.001	1	.981
Aggression (n=23)	12 **(53.8%)**	11 **(46.2%)**	.059	1	.808

4.3.4. OCD identification rates for individual vignette subtypes

Figure 2 shows OCD identification rates for the five vignette subtypes (contamination and symmetry are combined). We can see from the graph that the contamination/symmetry variable has the highest rates of OCD identification at 73.4%. The recognition rates for the other 4 vignettes are all below 40%, with aggressive obsessions the lowest at 26.7%.

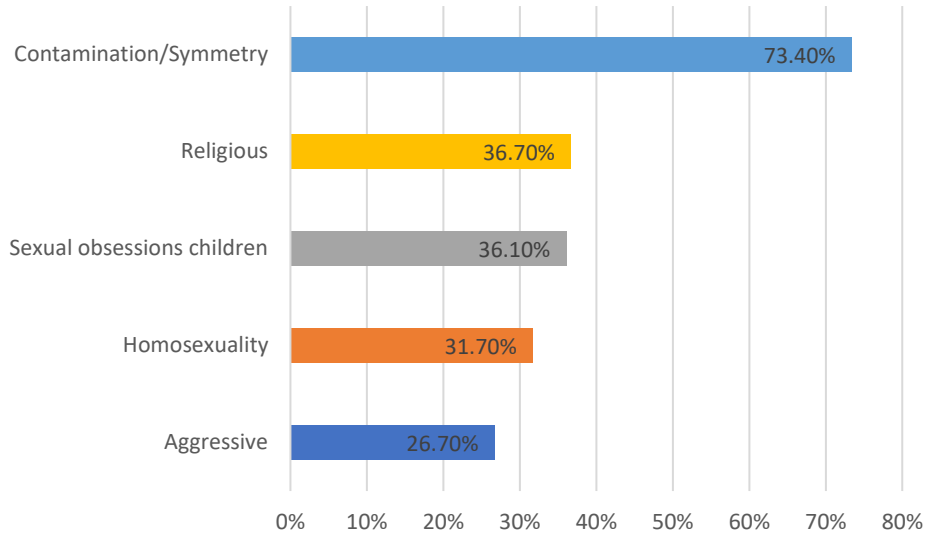

Figure 2. OCD identification rates x vignette type (n=514)

A chi-square analysis shows that there are some significant differences across OCD response and vignette type ($\chi 2$ (4, n = 243) = 81.729, p = .000). That is, the type of vignette presented to each respondent had a significant effect on whether they identified the clients presentation as OCD.

To further examine this effect a binary logistic regression was conducted. The data from the contamination and symmetry vignettes were combined, and this variable was used as the control condition in the regression. Therefore, the regression analysis was testing whether the odds ratios for correctly identifying OCD in the taboo intrusive thoughts vignettes were similar, or significantly different, to the odds ratio of the contamination/symmetry vignette. Table 6 presents the results of the regression.

Table 6. Results of a Binary Logistic Regression on OCD response and Vignette Type (n=514)

Vignette Type	Correct response (%)	Wald's $\chi 2$	p. value	Odds Ratio**
Paedophilia	36.1%	31.299	.000	.205
Aggressive	26.7%	46.862	.000	.133
Religious	36.7%	29.502	.000	.211
Homosexuality	31.7%	37.689	.000	.169
Contamination/symmetry*	77.3%	---	---	---

**Control variable*

******* The odds ratio is the probability of something happening. If levels of OCD identification for the taboo intrusive thoughts and the contamination/symmetry variable were exactly the same, then the odds ratios for those four variables would be 1.000.*

Table 6 shows that there is a significant effect for the paedophilia, aggressive, religious and homosexuality vignette subtypes, when contamination/symmetry is used as an anchor point. From the table we can conclude that in this study:

- a respondent presented with the *paedophilia* vignette had odds of **.205** for identifying OCD in comparison to someone presented with the *contamination/symmetry* vignette

- a respondent presented with the *aggressive* vignette had odds of **.133** for identifying OCD in comparison to someone presented with the *contamination/symmetry* vignette

- a respondent presented with the *religious* vignette had odds of **.211** for identifying OCD in comparison to someone presented with the *contamination/symmetry* vignette

- a respondent presented with the *homosexuality* vignette had odds of **.169** of identifying OCD in comparison to someone presented with the *contamination/symmetry* vignette

We can therefore accept hypothesis 1, that participants will be significantly less likely to identify the taboo intrusive thoughts vignettes as OCD, in comparison to the contamination and symmetry vignettes.

4.3.5. Confidence in responses to question 6

Figure 3 shows participants levels of confidence for question on OCD identification. Most participants were at least moderately confident in their responses.

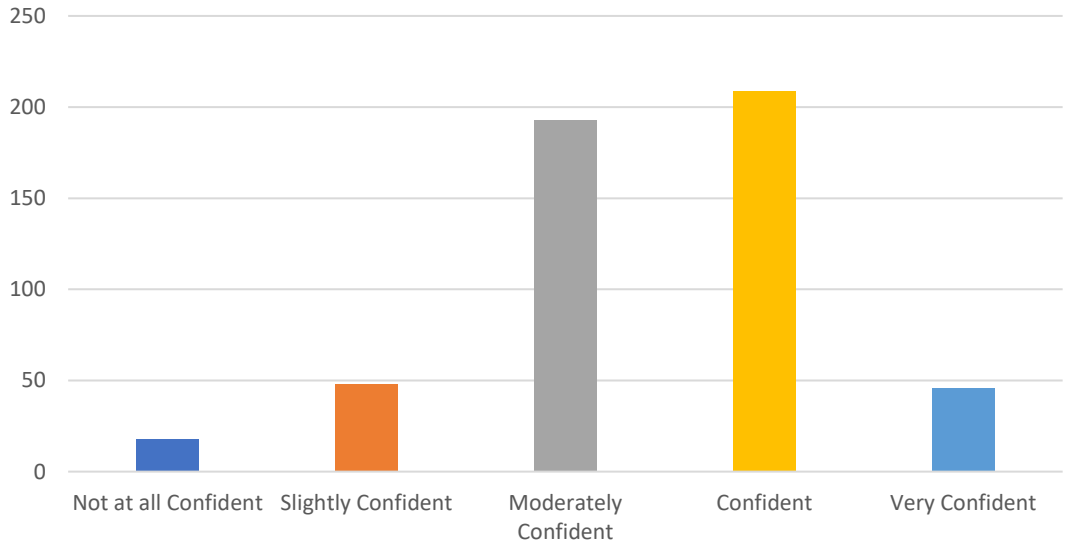

Figure 3. How confident are you in your choice(s) to question 6? (n=514)

**This figure is presented relative to how the variable rated for statistical purposes. For example, not at all confident = 1,…very condifent = 5). The higher the score the more confident the participant was in their answer to question 6.*

There were no significant differences between the confidence levels of those who identified OCD and those who did not (U=32135.500, p=.616). While there was a trend across all vignette subtypes for those who identified OCD to report lower levels of confidence in their response, there were no significant differences: paedophilia (p=.960), aggressive (p=.642), religious (p=.221), contamination (p=.596), symmetry (p=..804) and homosexuality (p=.103).

4.4. Responses to question 8: EBT Recommendations

4.4.1. Frequency of responses overall

Table 7 shows the total responses to question 8: *Which form of therapy do you feel would be the most beneficial as the first line of therapy for the client?* The total number of therapies selected by participants was 778, which gives an average of 1.51 per respondent. Humanistic therapy was the most frequent choice (n=223), followed by cognitive therapy (n=207) and behavioural therapy (n=61). Three participants selected 'none of these apply', while 79 participants selected 'other'.

Table 7. Question 8: Which form of therapy do you feel would be the most beneficial as the first line of therapy for the client? (n=778)

Therapies	Number selected	Therapies	Number selected
Acceptance and commitment therapy	20	***Biofeedback***	1
Cognitive therapy	207	***Hypnosis***	4
Existential therapy	8	***Behavioural therapy***	61
Exposure and response prevention therapy	30	***Transpersonal therapy***	2
Gestalt therapy	20	***Spiritual therapy***	3
Group therapy	4	***Family therapy***	0
Humanistic therapy	223	***Mindfulness***	40
Object relations therapy	4	***None of these***	3
Psychoanalytical therapy	11	***Body-oriented therapy***	14
Psychodynamic	44	***Other***	79

The top three recommendations for each vignette type are highlighted in the table 8. With the exception of the paedophilia and homosexuality vignette's (where the preferences are reversed), cognitive therapy was the most frequent therapeutic modality selected, followed by humanistic therapy. When the responses for the 4 taboo intrusive thoughts vignettes are

combined, humanistic therapy (n=148) was the most frequent response, followed by cognitive therapy (n=121), psychodynamic therapy (n=34) and behavioural therapy (n=30). For a full overview of responses to question 8 for each vignette subtype individually, please see appendix 6.

Table 8. Q8: The number of responses, the most frequent recommendations and number of recommendations for ERP, per vignette type.

	Paedo (n=83)	Aggress (n=86)	Religious (n=79)	Contam (n=97)	Symm (n=87)	Homosex (n=82)
Total number selected	123	117	119	155	148	116
Average number selected	1.48	1.36	1.51	1.60	1.70	1.41
Most frequent choice	41 (HT*)	34 (CT**)	33 (CT)	43 (CT)	43 (CT)	45 (HT)
2nd most frequent choice	32 (CT)	32 (HT)	30 (HT)	39 (HT)	36 (HT)	22 (CT)
3rd most frequent choice	9 (PT***)	7 (BT****)	11 (BT)	13 (BT)	18 (BT)	6 (PT)
ERP	5	6	2	12	4	1

** Humanistic therapy, ** Cognitive therapy,* ***Psychodynamic therapy, **** Behavioural therapy

4.4.2. Frequency of evidence-based therapy recommendations

The number of participants who selected ERP as a first line of treatment was low (30, 5.8%). with the contamination vignette accounting for 40% (12) of the responses. Overall, 207 (40.3%) of participants selected cognitive therapy as a form of therapy which they felt would be beneficial as a first line of therapy for the client. While both the symmetry and contamination

vignettes reported the highest level of cognitive therapy responses at 49.4% and 44.3% respectively, and homosexuality the lowest at 26.8%, there were no significant differences in cognitive therapy responses across the 6 vignette subtypes ($\chi 2$=10.050, p=.074).

As the number of participants who selected ERP was small, it was decided to combine both the ERP and cognitive therapy responses into one variable[18], in order to capture all of the participants who selected a form of EBT for their client. As a result, 223[19] (43.4%) of the participants were now considered to have selected an EBT. Figure 4 shows the relationship between selection of an EBT and vignette type.

There was a significant difference between the 5 vignette subtypes for the number of participants who selected an EBT (see figure 4) ($\chi 2$ (4, n=223) =11.156, p=.025). A binary logistic regression showed that those who were presented with the homosexuality vignette were significantly less likely to recommend an EBT for their client in comparison to those presented with the contamination/symmetry vignettes ($\chi 2$ (1) =10.801, p = .001). There were no significant differences for the other vignette subtypes in comparison to the contamination/symmetry variable.

[18] This new variable is EBT

[19] 14 participants selected both ERP and cognitive therapy as a first line treatment

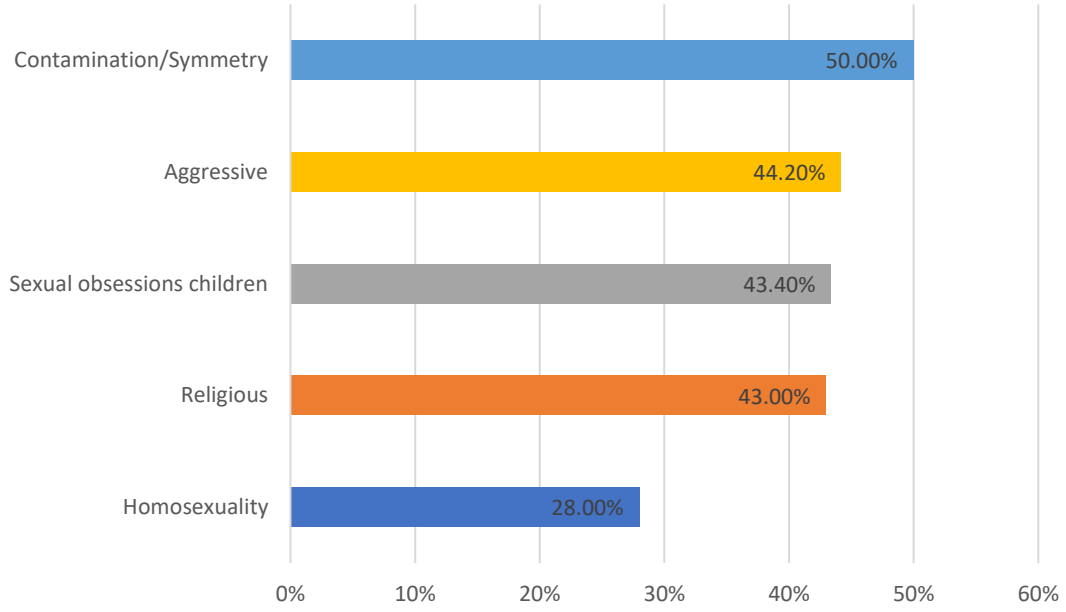

Figure 4. Vignette type and the selection of an evidence based first line of therapy (n=514)

4.4.3. Confidence in responses to question 8

Figure 5 shows that 311 (64%) of participants were confident or very confident in their responses to question 8.

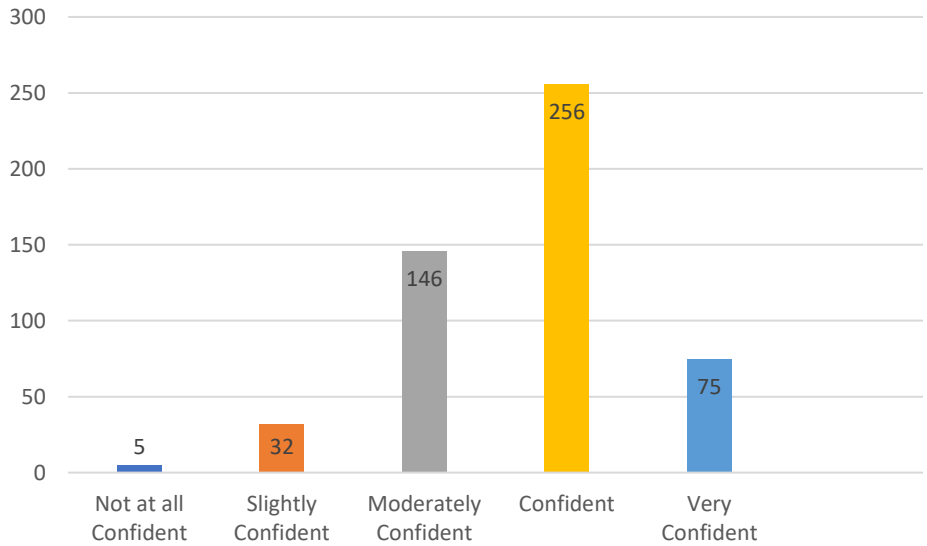

Figure 5. How confident are you in your choice(s) to question 8? (n=514)

**This figure is presented relative to the how the variable was rated for statistical purposes. For example not at all confident = 1,…very condifent = 5). The higher the score the more confident the respondent was in their answer to question 8.*

There was a significant difference in confidence levels between those who recommended an EBT and those who did not (U=26543.500, p=.000). Those who recommended ERP or cognitvie therapy as a first line therapy for their client (mean Rank = 231.03) were significanly less likely to have confidence in their decision than those who did not recommend ERP or Cognitie therapy as a first line therapy (mean rank = 277.79).

Those who chose humanistic therapy as a first line of treatment (mean rank=272.77) were significantly more likely to be confident in their decision than those who did not choose humanictic therapy as a first line treatment (mean rank=245.80) (U=29041.000, p=.027).

4.5. OCD Identification and the recommendation of an EBT

Figure 6 shows the connection between EBT recommendation and OCD identification. There is a large significant effect between these 2 variables ($\chi 2$ (1, n = 138) = 33.718, p = .000). That is, those who selected an EBT were significantly more likely to have identified OCD in their vignette than those who did not select an EBT. We can therefore accept hypothesis 2, that participants who identify their vignette as OCD will be significantly more likely to recommend an EBT for the client than those who do not identify OCD. Figure 6 illustrates this dynamic.

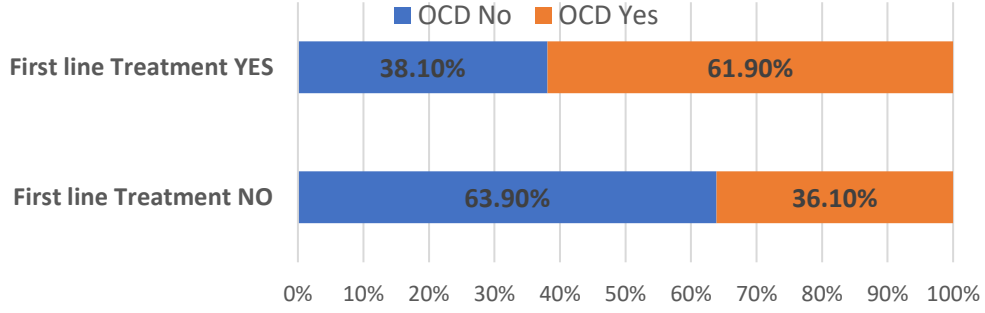

Figure 6. EBT recommendations v OCD identification (n=514)

4.6. Potential for harm and willingness to work with the client?

Figure 7 shows the result from question 10: *Based on the evidence presented in the vignette, in your opinion how likely is it that the client could harm another person*? As the graph shows, most participants (n=430) felt that it was either somewhat unlikely, unlikely, or very unlikely that the client presented in their vignette could harm another person.

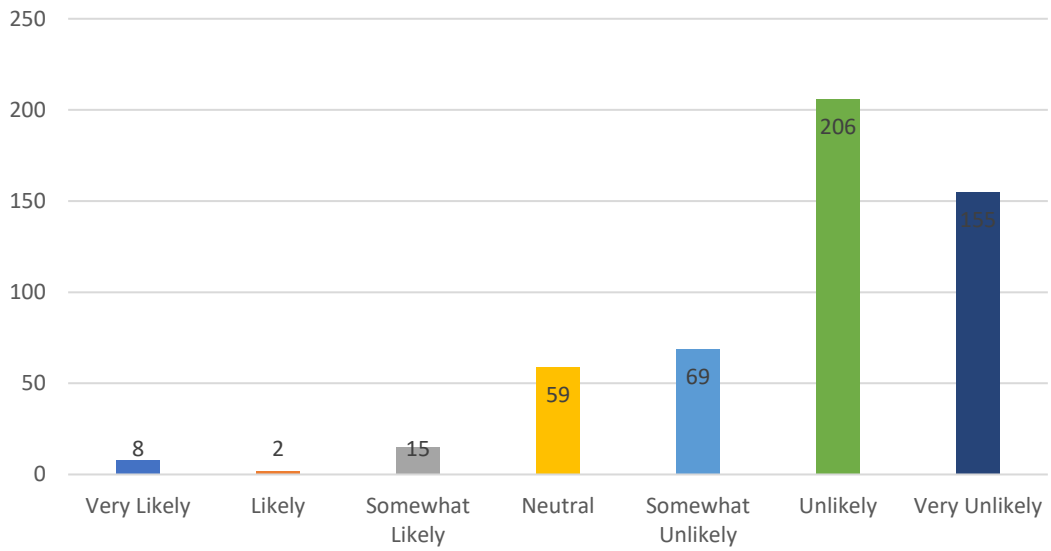

Figure 7. Based on the evidence presented in the vignette, in your opinion how likely is it that the client could harm another person? (n=514)

**This figure is presented relative to the how the variable was rated for statistical purposes. For example very likely = 1, likey = 2,……..very unlikely = 7). The higher the score the less likely the client could harm another person.*

Figure 8 shows the result from question 11: *Would you be willing to work with this client*? As the graph shows, most participants (n=482) felt they would be either somewhat willing, willing, or very willing to work with the client from their vignette.

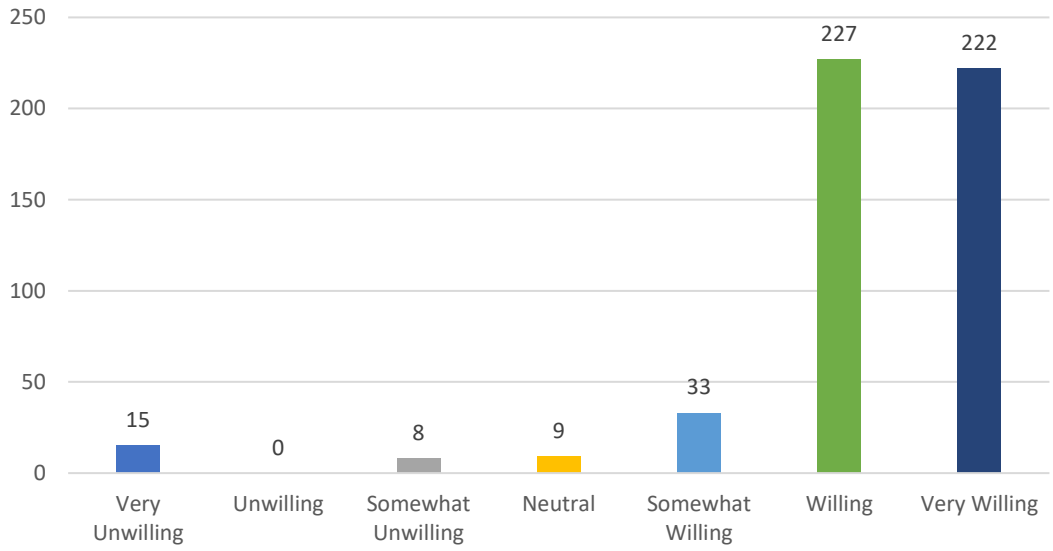

Figure 8. Q11 Would you be willing to work with this client? (n=514)

*This figure is presented relative to the how the variable was rated for statistical purposes. For example very unwilling = 1, unwilling = 2,……..very unwilling = 7). The higher the score the more likely the respondent would be willing to work with the client.

There were no significant differecnes in 'potenital for harm' between those who identified OCD in their vignette (mean rank = 266.22) and those that did not identify OCD (mean rank = 249.68) (U = 30806.500. p = .185). Also, there were no significant differecnes in 'willingess to work with the client' between those who identified OCD in their vignette (mean rank = 249.17) and those that did not identify OCD (mean rank = 264.97) (U = 30902.000. p = .187). When analyising each vignette subtype indivually for the 'potential for harm' harm and 'willigness to work with' variables in relation to OCD identification, the only vignette subtype with significant differences was the agressive vignette. Participants who were presented with the agressive vignette and who identified OCD, were significantly less likely (mean rank 54.52) to believe that their client could harm another person compared to those who did not identify OCD (mean rank 39.48) (U = 471.000, p.= .010).

Figure 9 highlights the question of 'potential for harm' across all five vignette subtypes (the contamination and symmetry vignettes are combined again). There is a statistically significant difference in 'potential for harm' across the 5 vignette subtypes (H = 26.919, p = .000). Figure 9 shows the mean ranks for each vignette subtype, with clients with aggressive intrusive thoughts considered by participants the most more likely to harm someone.

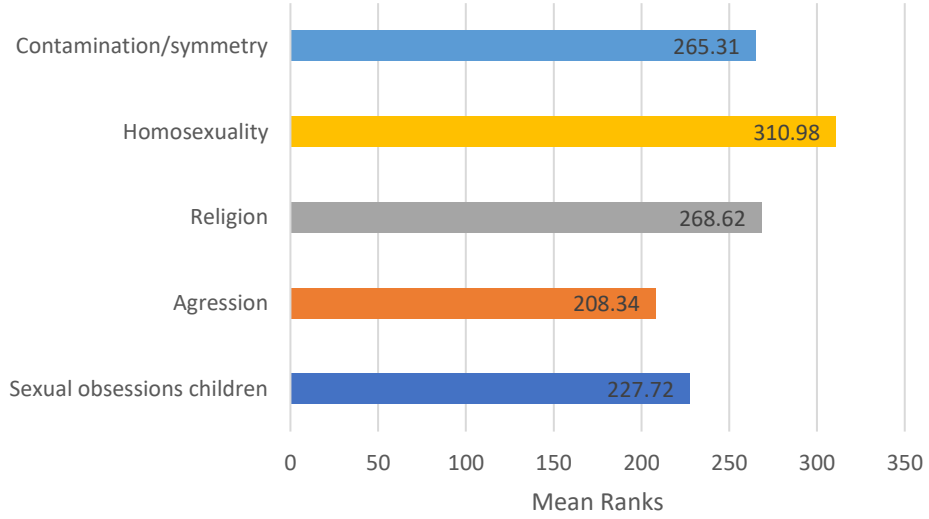

Figure 9. In your opinion, how likely is it that the client could harm another person ***x*** *vignette type? (n=514)*

To further examine this effect an ordinal logistic regression was conducted. Once again, the data from the contamination and symmetry vignettes were combined, and this variable was used as the control condition in the regression. Table 9 presents the results of the regression.

Table 9. Results of Ordinal Logistic Regression on 'Dangerousness' and Vignette Type

Vignette Type	Wald's $\chi 2$	p. value	95% CI Lower bound	95% CI Upper Bound
Paedophilia	4.406	.036	-.979	-.033
Aggressive	9.489	.002	-1.203	-.267
Religious	.030	.862	-.440	.527
Homosexuality	7.001	.008	.171	1.148
Contamination/symmetry*	---	---		

**Control variable*

We can see from table 9 that the predicted responses for the aggressive and paedophilia vignettes were significantly different from the contamination/symmetry variable. Participants presented with the aggressive and paedophilia vignettes perceived their client to be significantly more likely to harm another person than participants presented with the contamination/symmetry vignettes. On the other hand, participants presented with the homosexuality vignette perceived their client to be significantly less likely to cause harm than those presented with the contamination/symmetry variable.

Figure 10 highlights the question of 'willingness to work with the client' across the 5 vignette subtypes (the contamination and symmetry vignettes are combined once more). Statistical analysis show that there is a statistically significant difference in willingness to work with the client (H=10.193, p = .037). Figure 10 also shows the mean ranks for each variable, with clients from the aggressive vignettes the ones that participants would least likely be willing to work with. In comparison to the potential for harm' question, the paedophilia vignettes scored higher than the contamination/symmetry vignettes.

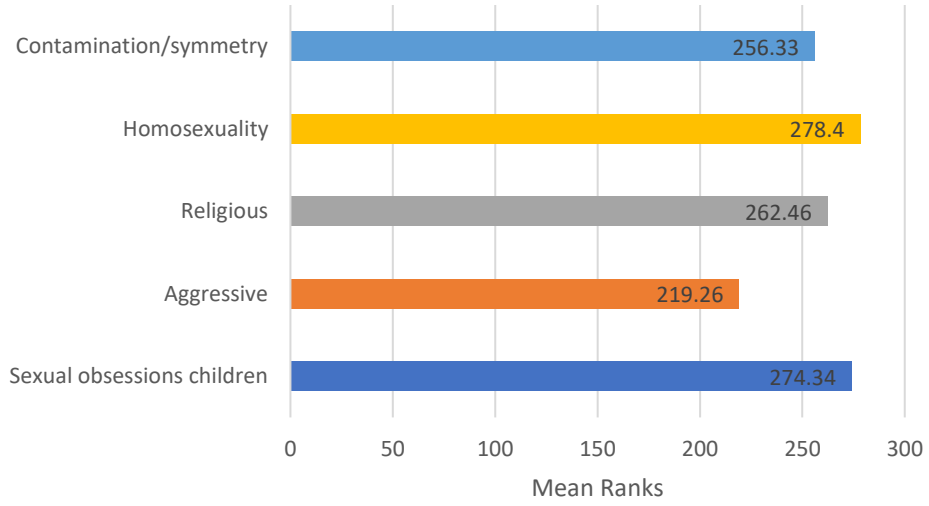

Figure 10. How willing would you be willing to work with the client x vignette type?

To further examine the effect of vignette type and 'willingness to work with' an ordinal logistic regression was conducted. Once again, the data from the contamination and symmetry vignettes were combined, and this variable was used as the control condition in the regression. Table 10 presents the results of the regression.

Table 10. Results of Ordinal Logistic Regression on 'Willingness to Work With' and Vignette Type

Vignette Type	Wald's $\chi 2$	p. value	95% CI Lower bound	95% CI Upper Bound
Paedophilia	1.035	.309	-.239	.754
Aggressive	4.368	.037	-1.003	-.032
Religious	.105	.745	-.419	.585
Homosexuality	1.732	.188	.164	.836
Contamination/symmetry*	---	---		

**Control variable*

We can see from table 10 that the predicted responses for aggressive intrusive thoughts are significantly different from the contamination/symmetry intrusive thoughts. Participants presented with the aggressive vignettes were significantly less willing to work with their client than those from the contamination/symmetry obsessions vignettes. There were no other significant predictors.

From the analysis presented on tables 9 and 10 we can accept hypothesis 3, that participants who were presented with the paedophilia and aggressive vignettes will be significantly more likely to feel that their client could potentially harm another person, and significantly less likely to be willing to work with their client, in comparison to the contamination and symmetry vignettes. The only outliner to this finding is that participants presented with the paedophilia vignettes were more willing to work with their client than those presented with the contamination and symmetry vignettes, although the result was not significant.

4.6.1. The effect of client gender

While there was a trend for participants to perceive the male client as more likely to cause harm and to be less willing to work with them, there were no significant effects for the gender - (U =30658.000, p=.145) and (U = 31488.500, p=.327) respectively. Figure 11 shows the means effects for these results.

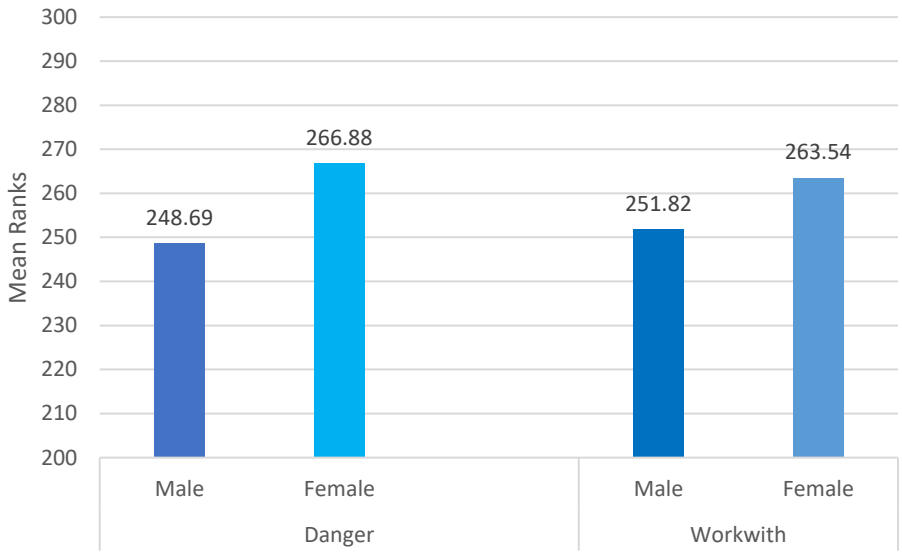

Figure 11. Perceived Dangerousness and Willingness to Work With x Vignette Gender (n=514)

4.7. Demographic variables

4.7.1. Demographic variables and OCD identification

Gender

There was some difference in OCD recognition rates in relation to the gender of the participants, 187 (49.5%) of females identified the clients as presenting with OCD, while 65 (41.7%) of males did so. However, the difference is not significant ($\chi 2$ (1, n=512) = 1.968, p = .374). There was a significant difference between female and male psychotherapists in their

confidence levels for their responses to this question. Males reported significantly higher confidence levels than females (U=22232.500, p=.025). Female therapists rates of OCD identification were higher than male therapists, but they had significantly less confidence in their responses in comparison to male therapists.

Experience

Figure 12 illustrates the connection between OCD recognition and therapists experience. We can see from the graph that therapists with the least experience (0-5 years) had higher rates of OCD identification. However, there were no significant differences amongst these groups in OCD identification ($\chi 2$ (2, n=243) =1.563, p= .211).

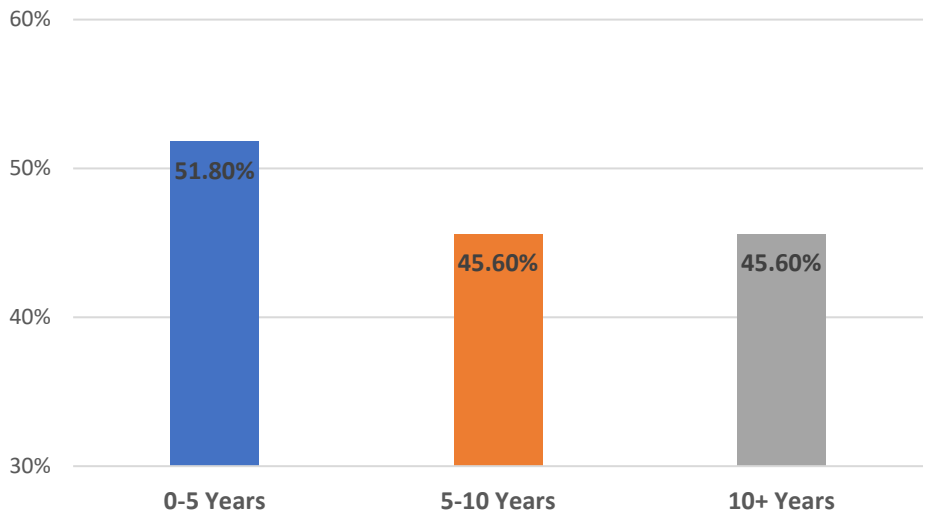

Figure 12. OCD identification x therapist's years of experience(n=243)

There was no significant difference in confidence levels for responses to question 6 and therapist's levels of experience (H=5.136, .077). However, if the 5-10 years and 10+ years groups are collapsed into on group (5+ years), and confidence levels compared, there is a significant difference. Therapists with 5 or less years' experience (mean rank 236.60) were

significantly more likely to report lower levels of confidence in their responses to question 6 than the more experienced therapists (mean rank 265.25) (U=23158.000, p=.038). One the other hand, as outlined in figure 12, therapist with the least experience (0-5 years) had higher rates of OCD identification than more experienced therapists.

Level of qualification

Figure 13 shows OCD identification against level of qualification. As the table shows, there were no significant differences between level of qualification and OCD identification ($\chi 2$ (3, n = 503) =.6.940, p = .326). There were also no significant differences between levels of confidence and therapist qualification level (U=7.423, p=.060).

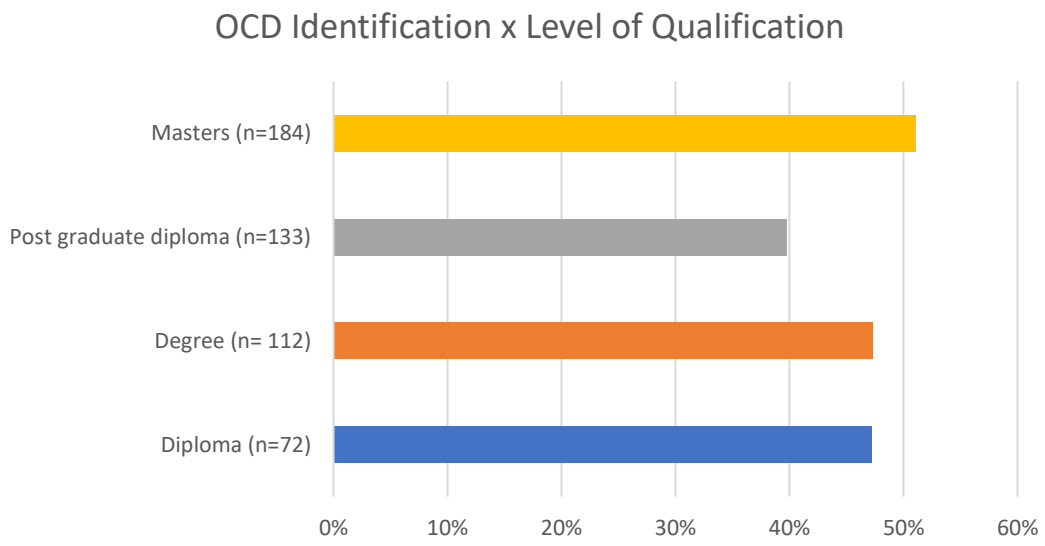

Figure 13. OCD Identification x Level of Qualification

4.7.2. Demographic variables and EBT recommendations

There were no significant differences between EBT recommendations and the gender of participants ($\chi 2$=1.649, p=.438), their experience levels ($\chi 2$=1.108, p=.575) and their level of qualification ($\chi 2$=4.553, p=.602).

4.7.3. Demographic variables and potential for harm and willingness to work with

Female participants (mean rank =247.51) were significantly less likely overall to be willing to work with the client presented in their vignette than male participants (mean rank = 281.86). (U=21928.000, p = .011). There were no significant effects for gender of participants in each of the six vignettes individually.

There were no significant differences overall for gender of participants and perceived dangerousness (U=24923.000, p = .773), or in each of the six vignettes individually.

4.8. Conclusion

The analysis of the data has shown that we can accept all 3 of the hypotheses proposed in this study. The implications of this will be considered next in the discussion. The analysis also found some interesting dynamics in the three areas for exploration, which will also be discussed.

Chapter 5: Discussion

5.1. Introduction

The aim of this research study was to assess psychotherapists interpretations of, and reactions to, a client who presents with OCD, in particular with taboo intrusive thoughts. The main findings were that psychotherapists who participated in the study were significantly more likely to identify their client's presentation as OCD for the contamination and symmetry subtypes of OCD in comparison to the taboo intrusive thoughts subtype. Overall, those who identified their client's presentation as OCD were significantly more likely to recommend a first line evidence-based therapy for their client. Participants were also significantly more likely to believe that their client could potentially harm another person and to be less willing to work with them if they presented with some forms of taboo intrusive thoughts.

The results will now be discussed in detail, in particular how they relate to previous research. The and implications of the results will also be discussed, as will potential solutions to the implications of the results. The strengths and limitations of the study will be considered and ideas for future research stemming from the findings will be examined.

5.2 Discussion of Results

5.2.1. Hypothesis 1: OCD Identification

Overall, less than half of respondents in this study identified their client's presentation as OCD. Glazier et al. (2015a) and Glazier et al. (2013), who used the same vignettes in their study with

primary care physicians and mental health professionals, had overall OCD identification rates of 49.5%. and 61.1%. respectively. Participants in this study were significantly more likely to identify OCD in the contamination/symmetry vignettes compared to the taboo intrusive thoughts vignettes.

It is worthwhile to assess how these results amongst psychotherapists compare to previous research (Glazier et al, 2013; Glazier & McGinn, 2015). Figure 14 presents an overview of identification rates across six vignette subtypes for this study and those by Glazier et al. (2013, 2015a). The graph clearly demonstrates that in these studies contamination and symmetry vignettes are significantly more likely to be identified as OCD compared to taboo intrusive thoughts vignettes. These findings have also been replicated in previous research assessing this phenomenon in the general public (Garcia-Soriano & Roncero, 2017; McCarty et al., 2017).

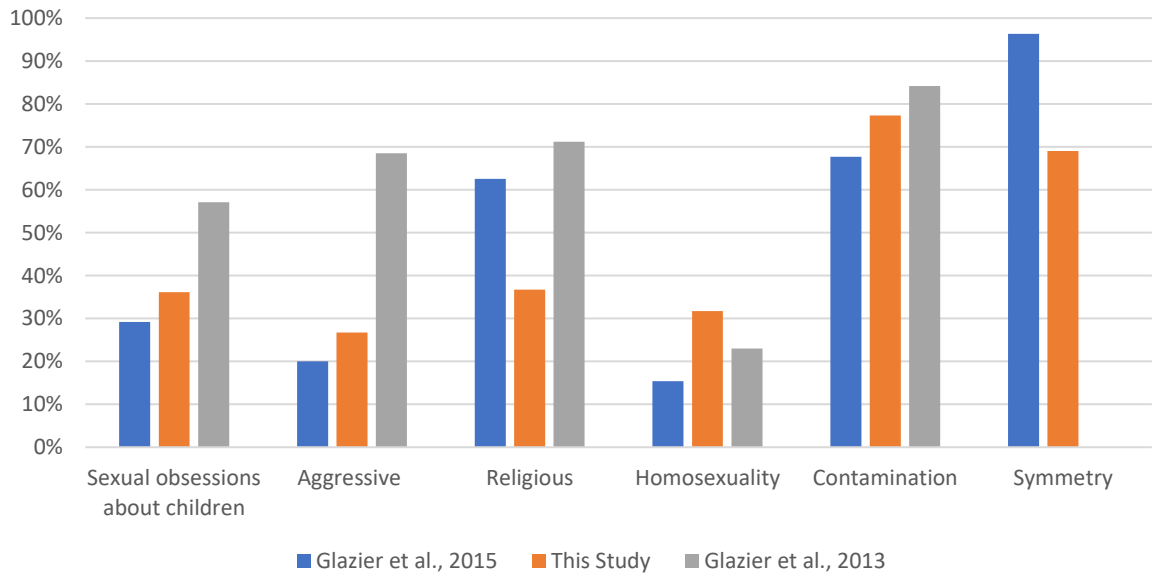

Figure 14 Identification rates for vignette subtypes for this study, Glazier et al. (2013) and Glazier et al. (2015a).

5.2.2. Hypothesis 2: Association between OCD identification and EBT recommendations

Overall, 43.4% of participants in this study recommended an EBT. Humanistic and cognitive therapy were the two most frequent therapy recommendations for the client. Cognitive therapy was marginally the more popular choice for the aggressive, religious, contamination and symmetry vignettes. Humanistic therapy was more strongly recommended for the sexual vignettes (homosexuality and paedophilia). Only 30 (5.8%) of participants overall recommended ERP as a first line treatment. Additionally, only 14 (4.2%) of participants who were presented with the taboo intrusive thoughts vignettes recommended ERP as a first line treatment. This is very low.

Participants who selected an EBT were significantly more likely to identify OCD in their vignette than those who did not. Glazier et. al. (2015a) also reported this phenomenon as significant in their study. It is difficult to make direct comparisons with that study, as they also used SSRI medications as a treatment recommendation. However, 66% of participants in that study who identified OCD recommended CBT, in comparison to 46.7% of those who did not identify OCD. Also, in this study, those who recommended humanistic therapy (not an EBT) were significantly less likely to correctly identify OCD in their vignette. These results suggest that there is a strong relationship between the correct identification of OCD and the recommendation of an EBT.

5.2.3. Hypothesis 3. Potential for harm and willingness to work with client

Overall, the majority of participants believed that their client was unlikely to harm another person. Most participants were also willing or very willing to work with their client, assuming they had the experience and skills to do so. There were no significant differences between those

who did or did not identify OCD and the client's potential for harm and willingness to work with.

The questions on the client's potential to harm someone and the participants willingness to work with them were essentially an initial exploration of these issues. While these questions have been asked regularly amongst the general population, there has been little, if any, exploration with psychotherapists or mental health professionals. The objective in this study was to assess if there were any differences in relation to taboo intrusive thoughts and the results were instructive. The paedophilia and aggressive vignettes were perceived as more likely to cause harm and the aggressive vignette as less willing to work with. These results are based on a lack of awareness of the genesis of OCD and its presentation, rather than any potential for harm.

These findings amongst psychotherapists also corroborate previous research with the general public - that individuals with taboo intrusive thoughts are more likely to be perceived with more fear and stigma than the more recognisable forms of OCD (Corcoran & Woody, 2008; Cathey & Wetterneck, 2013; Durna, Yorulmaz & Aktaç, 2019; McCarty et al., 2017; Simonds & Thorpe, 2003). McCarty et al. (2017) also reported that individuals who correctly identified their vignette as OCD reported lower levels of fear and wanted significantly less social distance from the individual than those who did not identify OCD. In this study, participants who were presented with the agressive vignettes and who identified their vignette as OCD were significantly less likely to believe that their client could harm another person. This finding and that of McCarty et al. (2017) outline the importance of OCD recgontinon in the prerception of cleints who present with unacceptabe intrusive thoughts.

5.2.4. Exploration 1: Effect of gender of the client

The exploration of the effects of the gender of the client is a novel and interesting one. There were no significant differences in OCD recognition overall for the gender of the client, and across each of the six vignette subtypes individually. In some respects, this was a surprising outcome, although the direction of any differences would have been difficult to predict. On the one hand males with OCD are more likely to present with sexual, religious and aggressive symptoms than females (Mathis, 2011). Therefore, one may have presumed that the taboo intrusive thoughts with a male client (John) would have being more readily identified as having OCD.

On the other hand, the perception of the potential for harm for an individual with a mental health problem is often greater when the character presented in vignettes is male (Sowiso et al., 2017). Also, taboo intrusive thoughts are sometimes misinterpreted as indicating risk (Bruce et al., 2018; NICE, 2005). Therefore, one could have assumed that participants would respond to Q6 with more responses which rightly or wrongly indicate risk (such as paedophilia, impulse control disorders, psychosis), for the male client's in the vignettes in comparison to the females clients, rather than OCD. However, as we will see further on in this discussion, that was not the case.

In relation to this, there was a trend towards perceiving the male client in the vignettes as more likely to harm another person, but it was not significant. There was also a trend for participants being less willing to work with the male client, but it was also not significant. There were no significant differences for gender and dangerousness and willingness to work with across the

6 vignette subtypes individually, except for homosexuality where participants perceived the male client as more dangerous and were less willing to work with them.

5.2.5. Exploration 2: The confidence variable

Confidence levels for responses relating to both question 6 (OCD identification) and question 8 (treatment recommendations) were high overall. However, confidence levels were not a good predictor of OCD identification or the recommendation of an EBT. There were no significant differences in confidence levels overall between those who identified OCD and those who did not, nor across any of the six vignette subtypes. However, those who recommended an EBT had significanly less confidence in their decision than those who did not, while those who recommeded humanistic therpay (not an EBT) were significantly more likely to be confident in their decision than those who did not. When we consider that those who recommended humanisitc therapy were significantly more likely to misidentify OCD is considered, we see another example where particpants confidnece in their responses was soewhat misguided.

5.2.6. Exploration 3: Interesting differences across demographic variables

Females psychotherapists were more likely to identify their vignettes as OCD than male psychotherapists, although it was not a significant difference. On the other hand, male psychotherapists were significantly more likely to be confident in their responses to the OCD identification question than female psychotherapists. Less experienced psychotherapists (less than five years) were also more likely to identify their vignettes as OCD, although once again it was not significant. However, they were significantly less confident in their responses than their more experienced counterparts. This is another clear example of the deceptive nature of confidence responses across the study.

While female participants did not view their clients are more dangerous than male participants, they were less willing to work with them. There were no significant findings in relation to type of qualification. Most core training was in humanistic and integrative psychotherapy. This was not a surprising result considering therapists accredited with IAHIP and IACP are predominately of this orientation.

5.3. Implications of the non-recognition of OCD

Some reasons have been put forward to explain the under recognition of intrusive thoughts in health care settings (Gyani et al., 2012). The first is the individual themselves may not present at a heath care setting. Many individuals with OCD do not seek treatment, particularly those with taboo intrusive thoughts. The contents of taboo intrusive thoughts are likely to lead to elevated levels of stigma and shame for the individual (Glazier et al., 2015b; McCarty et al., 2017), and elevated levels of embarrassment (Simonds & Thorpe, 2003). As already discussed, the results of this study show relatively low levels of stigma overall towards the presenting clients. However, it must be noted that stigma in relation to perceived dangerousness and willingness to work were higher for the aggressive and paedophilia vignettes, which corroborates previous research with the general public, and points to a lack of awareness of the different types of OCD manifestations.

Secondly, if the individual does present with the specific symptoms, the health care professional may recognise this as OCD. A positive relationship between symptom severity and seeking help has been reported in the literature (Mayerovitch et al. 2003). Therefore, individuals who present specifically in relation to their intrusive thoughts are likely to do so

because their symptoms have reached a level of severity that is having a more significant impact on their mental health and daily functioning. The clients presented in the vignettes in this study had a significant level of morbidity. However, as the results of this study with psychotherapists and previous research suggests, the disclosure of taboo intrusive thoughts to a health care professional does not guarantee that the problem with be correctly identified or an EBT recommended.

While OCD was the most common mental health problem selected in this study, GAD was also regularly selected. However, with the four taboo intrusive thoughts vignette combined, participants selected GAD (n=114) more frequently than OCD (n=108). The difference between intrusive thoughts in OCD and GAD have been outlined in the literature review. Other commonly selected misidentifications included PTSD, scrupulosity, phobias, perfectionism, OCPD and impulse control disorder. As highlighted by Glazier et al., (2013), these interpretations point to a lack of awareness amongst participants of the meanings of the symptoms presented in the vignettes, for example, interpreting religious intrusive thoughts as scrupulosity[20] or aggressive intrusive thoughts as impulse control disorder. It also points to a lack of understanding the important differentiation between ego-dystonic and ego-syntonic thoughts. There are important implications for not recognising OCD presentations in clients, such as the lack of appropriate intervention and the chronic struggle with the symptoms and the attendant issues that comes with this.

There are other potentially damaging consequences for the misinterpretation of taboo intrusive thoughts. Taboo intrusive thoughts can sometimes be interpreted as risk. As an example,

[20] Having strong moral or ethical standards and beliefs.

Glazier et al. (2013) reported that 37% of individuals presented with the paedophilia vignette in their study interpreted it as paedophilia. There are potentially very damaging consequences for an individual, who is highly distressed by their intrusive thoughts, being given such an interpretation or diagnosis by a mental health professional. While the objective in psychotherapy may not be to provide a diagnosis or to share one with a client, if such a misinterpretation is present in the mind of the therapist, it can only have damaging consequences for the therapeutic relationship and the client.

This form of misinterpretation was not really an issue in this study[21], with the possible exception where impulse control disorder[22] was selected by 12.8% of participants who were presented with the aggressive vignette (in comparison to 38% in Glazier et al., 2013). It is worth noting that such misinterpretations were also generally absent from the study by Glazier et al. (2015a). One potential explanation for this is that in this study and Glazier et al. (2015a), there was an introduction[23] to each vignette highlighting additional OCD characteristics. This may have led to less risk interpretations, and more interpretations such as GAD or PTSD or 'none of these apply[24]'. It did not, however, increase levels of OCD identification.

[21] The 3rd most frequent interpretation for sexual obsessions about children was PTSD (32). Only 3 participants selected paedophilia.
[22] Individuals with such intrusive thoughts are often quite rigid in terms of impulse expression, rather than the other way around.
[23] This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.
[24] 28 of participants in this study selected that 'none of these apply' for the paedophilia, aggressive and homosexuality vignettes combined, in comparison to 5 in total for contamination, symmetry and religious vignettes

5.4. Implications of non EBT recommendations

The literature review highlighted the fact that the majority of individuals who are diagnosed with OCD do not receive EBT, and the consequences of this in terms of remission rates and long-term morbidity (Fineberg et al., 2019; Grant, 2014; Stewart et al., 2019; Torres et al., 2007). The number or participants who recommended ERPT in this study was low. Even when recommendations for behavioural therapy[25] and ERPT are combined, only 16% of participants recommended one, or both, of these. Overall, 11.1% of participants recommended a dynamically based therapy (DBT) (psychodynamic, psychoanalysis or object relations therapy). When specifically examining the taboo intrusive thoughts vignettes, the recommendation rates for DBT's (8.6%) were higher than for ERPT and behavioural therapy combined. A closer inspection of the numbers shows that ERPT or behavioural therapy were recommended more frequently for the contamination and symmetry vignettes, while DBT's were more frequently recommended for the taboo intrusive thoughts' vignettes. It could be argued that because these number are low, that these finding have little relevance. However, this would miss some important points which are present here.

Firstly, of those who recommended a DBT, 38.6% correctly interpreted their client's presentation as OCD, while 61.4% did not. However, these differences were not significant, most likely because of the low number involved (n=57) and therefore there was insufficient statistical power to generate a significant result. Glazier et al. (2015) also reported that primary care physicians who recommended a DBT were less likely to identify OCD (Glazier et al., 2015). On the other hand, in this study those who recommended ERPT or behavioural therapy

[25] The assumption here is that those who recommended behavioural therapy may have determined that behavioural therapy is a potentially good intervention for their client, without the awareness that ERPT is the essential component.

were more likely to identify OCD. This is an example once again of the connection between interpreting the client's presentation as OCD and recommending an EBT.

Secondly, while DBT has been shown to be effective in the treatment of some mental health problems (Leichsenring, 2008), there is no evidence of their effectiveness[26] in treating the active symptoms of OCD. DBTs are generally not recommended as a first line treatment, when the client is often overwhelmed and distressed by their obsessions or compulsions (International Foundation OCD, 2020). Taboo intrusive thoughts are characterised by enormous levels of doubt. Attempting to gain insight into the origins of the client's distress may not be the most suitable intervention, and may actually exacerbate the problem (Glazier et al., 2015a).

5.5. Limitations of the study

Having participants make interpretations of a client's presentation from a vignette has its limitations, mainly because of their brevity, a point that was made by 21 participants in the study. The length of the vignettes in this study ranged from 126 to 154 words. The challenge is that they were developed based on the guidelines of a review of similar vignette based studies, which emphasised that clarity and brevity are critical factors (Veloski et al., 2005, as cited in Glazier et al., 2015a) in their development. The fact that participants could select up to three responses for the questions on OCD identification and the recommendation of an EBT, should have substantially offset this limitation. For example, the average number of responses

[26] It should be acknowledged that the methodologies used in assessing empirically supported therapies (RCT's) are not appropriate for assessing the effectiveness of DBT's. Please see Leichsenring (2008) for more discussion in this.

per participant for the OCD identification question was 1.78. It is possible that if only one response had been permitted, the levels of identification could have been lower. The vignettes had also been extensively validated and 97% of reviewers indicated that they met the diagnostic criteria for OCD (Glazier et al., 2015). Also, the fact that most participants felt confident in their replies suggests that the vignettes themselves were not a significant limitation in the study.

There are challenges inherent in generating high response rates in research surveys (Sauermann & Roach, 2013). Online surveys such as this one tend to have response rates of around 10–25% (Sauermann & Roach, 2013). The overall responses rate for this study was 22.5%, which puts it in the higher bracket relatively speaking. However, nonresponse bias[27] needs to be considered. Of the 52 respondents who started but did not complete the survey, all except one completed the demographic questions and did not go any further. They may have read the vignette and/or some of the questions and decided not to continue. The study author received approximately 8-10 emails from such individuals. They explained that they did not complete the survey because it did not fit with their values as a therapist (person-centred) and/or that they do not wish to diagnose or put labels on clients. In the study itself, 11 respondents replied to question six that they did select an option because they did not want to diagnose or label the individual.

These responses were in some way expected, as the majority of the sample were from a humanistic background, and there was some resistance to the survey in the pilot study. The point here is that if there is a non-response bias in the survey, some of it seems likely to relate

[27] Non-response bias occurs when the sample used in the analysis is not representative of the overall population the sample came from (Sauermann & Roach 2013).

to individuals unwillingness to participate because the content of the study was at odds with their approach to psychotherapy. As the results have shown, those who recommended humanistic therapies were less likely to identify OCD. Therefore, if any non-response bias can possibly be predicted from this study, it is that those who were more likely to not identify OCD were more likely to choose not to participate. Also, in consideration that the findings in this study have been robust across a number of different studies across different populations, it is unlikely that a non-response bias played a significant role in these findings.

There are some limitations with the potential for harm and willingness to work with questions. Ideally, these attributions would be assessed by with a number of items rated individually on a Likert scale, and an average score obtained. This is as was outlined by outlined by Brown (2008). For example, how scared of John would you feel? I would feel unsafe around John, I would feel threatened by John, and so forth (Brown, 2008).

5.6. Future research

It would be interesting to conduct a similar study including a control condition, such as another mental health problem. This could help distinguish whether the results from this study are in relation to a lack of awareness around OCD, or to a more general mental health literacy issue. As was discussed in the study limitations, the potential harm and willingness to work with questions were an initial foray into such dynamics amongst psychotherapist and health care professionals in general. More comprehensive research on these topics would be worthwhile as the literature strongly suggests that stigma is a major issues around taboo intrusive thoughs in the general public and it would be valuable to see the extent of such attitudes existed within the care profession also.

Further research assessing the implications of a lack of recognition of OCD on the therapeutic relationship would be valuable. This could be from both the perspective of therapists and clients. For the therapist it could be in terms of their struggle to empathise and come to grips with their clients symptoms and their and for the client the implications of not having their struggle with intrusive thoughts validated and accepted in some way within the relationship. It would be helpful to assess the number of people who attend psychotherapy as a first point of contact for a mental health problem, as opposed to emotional issues or stressful life events. There are however, challenges inherent in this for a variety of reasons, not least GDPR issues and the reluctance in psychotherapy to engage with diagnostic issues.

5.7. Application of the results

5.7.1. Psychopathology in psychotherapy training

Taboo intrusive thoughts are generally not given much attention in educational programmes for mental health professionals. Glazier and McGinn (2015) point out that the contamination subtype of OCD is more commonly presented in educational materials for mental health professionals, which may explain some of the discrepancy in recognition rates in previous studies with mental health professionals[28]. McDonough and Chigwedere (2013) argue that common forms of intrusive thoughts are often not adequately covered on CBT courses.

[28] The majority of whom were clinical psychologists

Psychopathology is generally given little, if any, attention in psychotherapy qualifications. This is generally a deliberate consideration, as the goal of humanistic and other psychotherapies is to work with the individual rather than with a particular diagnosis. However, as the results of this study have shown, there seems to be a lack of awareness relating to the presenting symptoms of OCD, in particular relating to taboo intrusive thoughts, and around recommended therapeutic interventions.

It should be acknowledged that psychotherapists are not qualified to give a formal diagnosis, a point made by some participants in this study. It was also apparent in the study that there was some resistance among participants to working with a diagnosis. While there is rationale and merit in the desire not to work with a diagnoses[29], but rather with the person, it should be acknowledged that a diagnosis of OCD could potentially help individuals such as those presented in the vignettes, both in terms of recognising that their thoughts are in fact common and not dangerous, and that the condition is treatable.

5.7.2 Screening for OCD

OCD has a high level of co-morbidity with other mental health problems. If an individual does present with OCD, it is often under the guise of a co-morbid mental health condition, rather than in relation to the intrusive thoughts themselves, which can makes recognition difficult. Individuals may prefer to discuss other emotional symptoms, as these issues are deemed more acceptable If there is a reliance on the reliance on spontaneous disclosure of taboo intrusive thoughts, then recognition rates are unlikely to improve (Torres et al., 2007).

[29] This was outlined by many therapists who completed the survey

Early recognition can enable early intervention which usually leads to more positive outcomes for individuals with OCD. Several screening tools have been developed for assessing the prevalence of OCD. The Yale-Brown Obsessive-Compulsive Scale (YBOCS), which assesses the prevalence of symptoms and their severity, is the gold standard and can be completed by an observer or be self-assessed. However, it takes a long time to complete and the those who rate it need to be trained (Hirschtrittet al., 2017). Alternatively, several shorter and effective self-administered screening tools are available (see Hirschtritt et al., 2017), which are more suitable for psychotherapists.

Psychotherapists should be aware of the possibility of the presence of obsessions and compulsions when a client presents with depressive or anxiety symptoms and inquire directly if they feel necessary. Lovell and Bee (2010) argue that routinely asking a series of direct questions is a useful way to start detecting OCD in care settings. Fineberg (2003, as cited in Wahl et al., 2010) reported from his research on OCD in dermatology clinics, that a direct inquiry by a sympathetic healthcare professional is often successful in enabling clients with OCD to open up about the problem.

McCafferty & McDonough (2019) present a short and useful set of screening questions for OCD in primary care, which could also be used by psychotherapists.

1. Are you experiencing any upsetting thoughts, images, or impulses, which keep repeating even though you try not to think about them? (Screening for obsessions)
2. Do you ever feel driven to repeat certain acts over and over- to reduce your anxiety or to prevent something bad from happening? (Screening for compulsions)

3. How much time does this take? Is it interfering in your life or causing you a lot of distress?
4. If necessary, the symptoms should be explored in greater detail

5.7.3. The value of a humanistic approach

Establishing and maintaining a strong therapeutic relationship is important with clients who present with symptoms of OCD, not least because it can enable the client to feel comfortable and safe enough to disclose their intrusive thoughts (APA, 2007). It can also help in planning and implementing any necessary interventions, be they referrals or within the current relationship (APA, 2007). The ability to explain the dynamics of OCD and any potential interventions while being encouraging and comforting is important, not least because of the high levels of doubt the individual has (APA, 2007).

5.7.4. Interventions for OCD in a community setting

A lack of availability of clinicians or therapists who are trained in in OCD-specific approaches has been identified as a major barrier in providing effective treatments for clients (Hirschtritt et al., 2017), and community-based practitioners need to play a role in addressing this gap (Shafran et al., 2009). Sunde et al. (2017) assessed the long-term effectiveness of group based ERPT in a general psychiatric outpatient clinic in Norway. The therapy was conducted by two psychotherapists, one psychiatrist and one psychologist who had limited experience with OCD but attended training in ERP for OCD before the start.

In an extensive follow up with 62% of the original clients, they reported a significant reduction in OCD, anxiety, and depressive symptoms post intervention, and at eight years follow up. Forty percent of participants had experienced either a clinically significant improvement (10%) or recovery (40%) in OCD symptoms at the eight year follow up. These finding outline the potential effectiveness for therapeutic interventions delivered in a community setting by therapists and clinicians.

5.7.5. Psychotherapists as first point of contact

According to Torres et al. (2007), 62% of individuals with OCD who they surveyed had talked to a general practitioner about emotional problems in the past year, and the literature suggests that individuals with OCD are more likely to attend primary care to seek help (whether directly or indirectly). People generally feel more comfortable talking with their GP regarding their mental health problems than with a mental health professional (Lester et al., 2005). Reluctance in attending a mental health professional for OCD can be due to fears of being considered insane, being hospitalised or arrested, and the stigma of attending these services (Glazier et al., 2015b). There is less stigma attached to attendance in primary care with mental health issues (Barry and Jenkins, 2019). However, primary care professionals generally do not have a mental health orientation and often have a lack of knowledge and skills.

While there is no research that the author is aware of, it is possible that individuals with OCD would feel more comfortable attending a psychotherapist than a mental health professional. It is assumed that those struggling with mental health problems generally attend their GP initially. The route to the mental health services in Ireland is generally through a GP, they are the first point of contact. However, it quite possible that people will choose to attend a psychotherapist

as a first point of contact. There is generally less stigma involved than with attending mental health services. It is usually not much more expensive than attending a GP (unless the individual has a medical card), it is generally a more comfortable and less stressful environment, there is more privacy, the client will receive more time and, of particular relevance for OCD, there is a strong ethos of confidentiality. There is little research about presentation rates with mental health problems in psychotherapy, and there are constraints inherent in psychotherapy practice for conducting this type of research. However, it is not beyond the bounds of possibility that quite number of people are presenting to psychotherapists with issues relating to OCD, whether these issues are specifically referred to or not.

5.8. Final Conclusions

This study examined psychotherapists awareness of the symptoms of OCD, in particular taboo intrusive thoughts. It also examined psychotherapists familiarity with evidence-based treatments for OCD and whether there were any stigma attributions towards the clients. The results corroborated previous research with health care professionals, that taboo intrusive thoughts are less likely to be identified as OCD, that those who do identify OCD are more likely to recommend an EBT and that stigma attributions are more prevalent for taboo intrusive thoughts than other forms of OCD.

This study also assessed participants levels of confidence in their responses and found that confidence was a poor predictor of OCD identification and EBT recommendation. It also examined whether the gender of the client in the vignette would have any effect on OCD identification, no effect was found. The implications and applications of these findings have been discussed. The study has highlighted a need for greater education and awareness around

OCD symptomology and what constitutes effective treatment for OCD amongst psychotherapists in Ireland.

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Appendices

Appendix 1: OCD Subtypes

Examples of the different obsessions/intrusive thoughts from the OCD subtypes relevant to this study are outlined below: taken from the Yale-brown Obsessive-Compulsive Scale (Goodman et al, 1989; Storch et al, 2010).

Symmetry Obsessions

1. Obsessions about symmetry or exactness

Worries about papers and books being properly aligned, worries about calculations or handwriting being perfect.

2. Same as above but accompanied by magical thinking:

For example, concerned one's mother will have an accident unless things are in the right place.

**These obsessions are usually accompanied by overt compulsions.*

Contamination obsessions

1. Concerns or disgust with bodily waste or secretions.

Fear of contracting AIDS, cancer, or other diseases from public rest rooms; fears of your own saliva, urine, faces, semen, or vaginal secretions.

2. Concern with dirt or germs.

Fear of picking up germs from sitting in certain chairs, shaking hands, or toughing door handles.

3. Excessive concern with environmental contaminants.

Fear of being contaminated by asbestos or radon, fear of radioactive substances, fear of things associated with towns containing toxic waste sites.

4. Excessive concern with household items.

Fear of poisonous kitchen or bathroom cleansers, solvents, Insect spray or turpentine.

5. Excessive concern with animals.

Fear of being contaminated by touching an insect, dog, cat, or other animal.

**These obsessions are usually accompanied by overt compulsions.*

Religious/moral obsessions

1. *(Scrupulosity) Concerned with sacrilege and blasphemy:*

Worries about having blasphemous thoughts, saying blasphemous things, or being punished for such things.

2. Excess concern with right/wrong, morality:

Worries about always doing "the right thing", having told a lie, or having cheated someone.

**Can be accompanied by overt and covert compulsions (e.g. concerns with sacrilege and blasphemy praying, studying bible).*

Aggressive Obsessions

1. Fear might harm self

Fear of eating with a knife or fork, fear of handling sharp objects, fear of walking near glass windows.

2. Fear might harm others

Fear of poisoning other people's food, fear of harming babies, fear of pushing someone in front of a train, fear of hurting someone's feelings, fear of being responsible by not providing assistance for some imagined catastrophe, fear of causing harm by bad advice.

3. Violent or horrific images

Images of murders, dismembered bodies, or other disgusting scenes.

4. Fear of blurting out obscenities or insults

Fear of shouting obscenities in public situations like church, fear of writing obscenities.

5.. Fear will act on unwanted impulses

Fear of driving a car into a tree, fear of running someone over, fear of stabbing a friend.

* *These obsessions are often accompanied by covert compulsions. For example, mental rituals, somatic checking, avoidance or reassurance seeking.*

Sexual Obsessions

1. Forbidden or perverse sexual thoughts, images, or impulses

Unwanted sexual thoughts about strangers, family, or friends.

2. Content involves children or incest

Unwanted thoughts about sexually molesting either your own children or other children.

3. Content involves homosexuality

Worries like “Am I a homosexual?” or “What if I suddenly become gay?” when there is no basis for these thoughts.

4. Aggressive sexual behaviour toward others

Unwanted images of violent sexual behaviour toward adult strangers, friends, or family members.

** These obsessions are often accompanied by covert compulsions. For example, mental rituals, somatic checking, avoidance or reassurance seeking.*

Appendix 2: Comparisons between OCD and other mental health problems

Below is an outline of mental health problems which have features of obsessional or intrusive thoughts, and how these differ from OCD.

- **Generalised Anxiety Disorder (GAD):** the worries or recurring thoughts of GAD are primarily concerned with realistic or everyday concerns; obsessions in OCD are more unusual and unrealistic in their themes. Worries and obsessions are also experienced differently. Worry is something that you "do" in order to problem solve - whereas obsessions "happen" - they intrude into consciousness fully formed.
- **Phobic Disorders:** In phobias, there is usually very little distress in the absence of the feared situation. There is also an absence of rituals.
- **Major Depressive Disorder:** Depression is commonly comorbid with OCD. Depressive rumination may be differentiated from obsessions in that ruminations are generally mood-congruent, ego-syntonic and not usually experienced as intrusive. Also, obsessions tend to trigger anxiety and doubt; whereas depressive ruminations trigger dysphoria and hopelessness.
- **Eating Disorders:** preoccupations are focused on food, weight or body image and the fear is of weight gain. The thoughts in eating disorders are ego-syntonic and the behaviours are purposeful.
- **Illness Anxiety Disorder:** This is characterized by recurring thoughts that are exclusively related to fear of currently having a serious disease.
- **Tic Disorders:** Tics are sudden, rapid, recurrent, non-rhythmic behaviours such as blinking, touching, grimacing or sniffing, and are not triggered by obsessions.
- **Psychotic Disorders:** Although people with OCD may have poor insight or even be delusional regarding the obsessions, they will not have hallucinations or formal thought disorder.
- **Obsessive Compulsive Personality Disorders:** Also known as anankastic personality disorder, this is often what people are referring to when describing themselves as "so OCD." It is characterised by traits of perfectionism, over-control (both interpersonally and mentally), excessive conscientiousness and rigidity. Such traits in OCDP are ego-syntonic, as opposed to OCD obsessions and compulsions which are ego dystonic.

(McCafferty & McDonough, 2019)

Appendix 3: Vignettes used in the study

Vignette A: Sexual obsessions about children (Male)

This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.

John, a middle-aged man, loved spending time with his nieces and nephews. However, he started having images of touching the children in a sexual manner. He had no desire to touch the children and did not experience any sexual arousal while having the images, but the worry of 'what if' remained. He now tries to avoid being with the children and refuses to spend time alone with them. He knows that the thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them.

Vignette B: Sexual obsessions about children (Female)

This client (Lorraine) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause her significant anxiety and distress.

Lorraine, a middle-aged woman, loved spending time with her nieces and nephews. However, she started having images of touching the children in a sexually inappropriate. She had no desire to touch the children and did not experience any sexual arousal while having the images, but the worry of 'what if' remained. She now tries to avoid being with the children and refuses to spend time alone with them. She knows that the thoughts come from within her own mind and are excessive in nature. However, even knowing this she remains upset by the thoughts and is not able to stop them.

Vignette C: Aggressive obsessions (Male)

This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.

John, a middle-aged man, thought about pushing the lady next to him onto the railway tracks. He was afraid of the thought and the fear that he might act on it, so he immediately left the train station and caught a taxi home. However, John remained worried and found himself frequently visualising the situation to make sure that he did not actually harm the lady. John

frequently finds himself worrying that he may want to, or will harm, others and these thoughts greatly upset him. He knows that his thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them.

Vignette D: Aggressive obsessions (Female)

This client (Lorraine) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause her significant anxiety and distress.

Lorraine, a middle-aged woman, thought about pushing the lady next to her onto the railway tracks. She was afraid of the thought and the fear that she might act on it, so she immediately left the train station and caught a taxi home. However, Lorraine remained worried and found herself frequently visualising the situation to make sure that she did not actually harm the lady. Lorraine frequently finds herself worrying that she may want to, or will, harm others and these thoughts greatly upset her. She knows that her thoughts come from within her own mind and are excessive in nature. However, even knowing this she remains upset by the thoughts and is not able to stop them.

Vignette E: Religious obsessions (Male)

This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.

John, a middle-aged, highly religious man, believes that one should not have any negative thoughts about religion. He greatly worries when he notices himself having such negative religious thoughts (e.g., why does God have bad things happen to good people?). When these 'bad' thoughts occur, as they frequently do, he becomes distressed and fears God will punish him. John then prays repeatedly to himself until he feels safe from harm and this can go on for hours. He knows that the thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them.

Vignette F: Religious obsessions (Female)

This client (Lorraine) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause her significant anxiety and distress.

Lorraine, a middle-aged, highly religious woman, believes that one should not have any negative thoughts about religion. She greatly worries when she notices herself having such negative religious thoughts (e.g., why does God have bad things happen to good people?). When these 'bad' thoughts occur, as they frequently do, she becomes distressed and fears God will punish her. Lorraine then prays repeatedly to herself until she feels safe from harm and this can go on for hours. She knows that the thoughts come from within her own mind and are excessive in nature. However, even knowing this she remains upset by the thoughts and is not able to stop them.

Vignette G: Contamination Obsessions (Male)

This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.

John, a middle-aged man, constantly worries about dirt and germs. He is unable to complete many of his daily activities because he tries at all costs to avoid touching things he thinks may be dirty. However, if he does touch a 'dirty' object, John will immediately wash his hands so that he will not catch a disease. He knows that his thoughts are excessive in nature and come from within his own mind. However, even knowing this he remains upset by the thoughts and is not able to stop them.

Vignette H: Contamination Obsessions (Female)

This client (Lorraine) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause her significant anxiety and distress.

Lorraine, a middle-aged woman, constantly worries about dirt and germs. She is unable to complete many of her daily activities because she tries at all costs to avoid touching things she thinks may be dirty. However, if she does touch a 'dirty' object, Lorraine will immediately wash her hands so that she will not catch a disease. She knows that her thoughts come from within her own mind and are excessive in nature. However, even knowing this she remains upset by the thoughts and is not able to stop them.

Vignette I: Symmetry obsessions (Male)

This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.

John, a middle-aged man, worries when things are not orderly or systematic. He becomes anxious when individuals move his belongings and feels he must immediately return the objects to their proper place. He also rearranges things that are not in order to place them how they "should be". When things are not in proper order John is unable to focus until the objects are back in their correct place. He knows that his thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them.

Vignette J: Symmetry Obsessions (Female)

This client (Lorraine) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause her significant anxiety and distress.

Lorraine, a middle-aged woman, worries when things are not orderly or systematic. She becomes anxious when individuals move her belongings and feels she must immediately return the objects to their proper place. She also rearranges things that are not in order to place them how they "should be". When things are not in proper order Lorraine is unable to focus until the objects are back in their correct place. She knows that her thoughts come from within her own mind and are excessive in nature. However, even knowing this she remains upset by the thoughts and is not able to stop them.

Vignette K: Homosexual obsessions (Male)

This client (John) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause him significant anxiety and distress.

John, a young adult, has been in a committed relationship with his girlfriend for over five years. He loves her very much and is attracted to her. Although he is not sexually attracted to men, John is preoccupied by thoughts that he may be gay and worries that he is not living an honest life. Upon seeing men, John immediately assesses his body for any signs that he may be sexually aroused; when he finds no signs of arousal, he experiences temporary relief. He knows that his thoughts come from within his own mind and are excessive in nature. However, even when knowing this he remains upset by the thoughts and is not able to stop them.

Vignette L: Homosexual obsessions (Female)

This client (Lorraine) attends for an initial therapy session at your practice with the following symptoms. The symptoms, unless stated, have been present for five years, are time consuming and cause her significant anxiety and distress.

Lorraine, a young adult, has been in a committed relationship with her boyfriend for over five years. She loves him very much and is attracted to him. Although she is not sexually attracted to women, Lorraine is preoccupied by thoughts that she may be gay and worries that she is not living an honest life. Upon seeing women, Lorraine immediately assesses her body for any signs that she may be sexually aroused; when she finds no signs of arousal, she experiences temporary relief. She knows that her thoughts come from within her own mind and are excessive in nature. However, even when knowing this she remains upset by the thoughts and is not able to stop them.

Appendix 4: Survey Questionnaire

Introduction

Hello, thank you for taking part in this Research Study investigating psychotherapists responses to a client with distressing psychological symptoms. After you complete some initial demographic questions, you will be presented with a scenario (vignette) which describes a client who has distressing symptoms. You will then be asked to answer some questions relating to the client. The total time to complete the questionnaire should be about 5 minutes. All responses are anonymous. You are free to withdraw at any time.

1. What is your Gender?

1. Female __
2. Male __
3. Other (please specify) __

2. How long have you being practicing as an accredited psychotherapist?

1. 0-5 Years __
2. 5-10 Years __
3. 10+ Years __
4. I am not yet accredited (student/pre-accreditation) __

3. What level is your psychotherapy Qualification?

1. Certificate __
2. Diploma __
3. Postgraduate Diploma __
4. Masters __
5. Phd __
6. Other (please specify) __

4. What was the Theoretical Orientation of your training?

1. Humanistic/Integrative __
2. Psychoanalytical __
3. Psychodynamic __
4. Gestalt __
5. Existential __
6. Cognitive Behavioural __
7. Family Therapy __

8. Body-Oriented __
9. Couples Therapy __
10. Other (please specify) __

5, Vignette presentation (please see appendix 1 to see vignettes)

6. In your opinion, do any of the following apply to the client?

**Please scroll back to read the vignette again if necessary*

1. Depression __
2. Anger management issues __
3. Narcissistic personality disorder __
4. Bipolar disorder __
5. Obsessive compulsive personality disorder __
6. Sex addiction __
7. Panic attacks __
8. Perfectionism __
9. Paranoid personality disorder __
10. Obsessive compulsive disorder __
11. Post-traumatic stress disorder
12. Paedophilia __
13. Borderline personality disorder __
14. Psychosis __
15. None of these apply __
16. Generalized anxiety disorder __
17. Social anxiety disorder __
18. Specific phobia __
19. Impulse control disorder __
20. Scrupulosity (strong moral or ethical standards) __
21. Other (please specify)

7. How confident are you in your choice(s) to the previous question?

1. Not at all Confident __
2. Slightly Confident __
3. Moderately Confident __
4. Confident __
5. Very Confident __

8. Based on the Vignette, which form of therapy do you feel would be the most beneficial as the first line of therapy* for the client?

**Which form of therapy would you recommend to use first?*

1. Acceptance and commitment therapy __
2. Group therapy __
3. Cognitive therapy __
4. Exposure and response prevention therapy __
5. Gestalt therapy __
6. Humanistic/Integrative therapy __
7. Existential therapy __
8. Object relations therapy __
9. Psychoanalytic therapy __
10. Psychodynamic therapy __
11. Biofeedback __
12. Family therapy __
13. Hypnosis __
14. Transpersonal therapy __
15. Refer to religious/spiritual leader or healer __
16. Mindfulness __
17. Behavioural therapy __
18. None of these apply __
19. Body-oriented therapy __
20. Other (please specify)

9. How confident are you in your choice(s) to the previous question?

1. Not at all Confident __
2. Slightly Confident __
3. Moderately Confident __
4. Confident __
5. Very Confident __

10. Based on the evidence presented in the vignette, in your opinion how likely is it that the client could harm another person?

1. Very Likely __
2. Likely __
3. Somewhat Likely __
4. Neutral __
5. Somewhat Unlikely __
6. Unlikely __
7. Very Unlikely __

11. Would you be willing to work with this client?

**For the purposes of this question please assume that you have the skills and experience to do so*

1. Very Unwilling __
2. Unwilling __
3. Somewhat Unwilling __
4. Neutral __
5. Somewhat Willing __
6. Willing __
7. Very Willing __

Appendix 5: Response frequencies for each vignette subtype for question 6 (OCD identification)

	Paedophilia (n=151)	Aggressive (n=142)	Religious (n=147)	Contamination (n=177)	Symmetry (n=168)	Homosexual (n=118)
Anger management issues	1	1	1	1	0	0
Bipolar disorder	1	0	0	0	0	0
Borderline personality disorder	3	7	1	0	0	2
Depression	9	7	6	4	4	0
Generalized anxiety disorder	29	29	29	22	29	27
Impulse control disorder	2	11	4	4	4	0
Narcissistic personality disorder	1	0	0	0	0	0
None of these apply	10	7	2	0	3	11
Obsessive compulsive disorder	30	23	29	75	60	26
Obsessive compulsive personality disorder	8	9	9	7	17	4
Other (please specify)	15	15	11	18	9	23
Paedophilia	3	1	0	0	0	1
Panic attacks	0	4	4	5	1	0
Paranoid personality disorder	5	4	2	0	1	2
Perfectionism	2	0	7	5	25	5
Post-traumatic stress disorder	20	8	6	11	13	4
Psychosis	0	4	2	0	0	0
Scrupulosity	5	4	29	3	1	7
Sex addiction	0	1	0	0	0	0
Social anxiety disorder	4	5	1	2	1	4

Specific phobia	3	2	4	20	0	2
Total number of issues selected	151	142	147	177	168	118
Average number per respondent	1.82	1.65	1.86	1.82	1.93	1.44

Appendix 6: Responses frequencies for each vignette subtype for question 8 (EBT recommendations)

	Paedophilia (n=123)	Aggressive (n=117)	Religious (n=119)	Contamination (n=155)	Symmetry (n=148)	Homosexual (n=116)
Acceptance and commitment therapy	6	1	4	2	4	3
Cognitive therapy	32	34	33	43	43	22
Existential therapy	1	0	4	2	0	1
ERP	5	6	2	12	4	1
Gestalt therapy	3	2	1	6	3	5
Group therapy	2	1	0	0	1	0
Humanistic therapy	41	32	30	39	36	45
Object relations therapy	1	0	0	0	1	2
Psychoanalytical therapy	2	4	1	2	1	1
Psychodynamic	9	6	9	4	6	10
Biofeedback	0	0	0	1	0	0
Hypnosis	0	0	1	2	1	0
Behavioural therapy	6	7	11	13	18	6
Transpersonal therapy	0	0	2	0	0	0
Spiritual therapy	0	0	3	0	0	0
Family therapy	0	0	0	0	0	0
Mindfulness	3	6	7	6	15	3
None of these	1	2	0	0	0	0
Body-oriented therapy	2	2	1	2	2	5
Other	9	14	10	21	13	12

ERPT and cognitive therapy	36	38	34	47	45	23
Total number of therapies selected	123	117	119	155	148	116
Number of respondents	83	86	79	97	87	82
Average number per respondent	1.48	1.36	1.51	1.60	1.70	1.41

Appendix 7: SPSS Analysis

For a copy of the SPSS analysis please contact the study author at:
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