Obsessive–Compulsive Disorder and Mental Health Literacy: Assessing Clinicians'

Knowledge Through Exposure to OCD Lived Experiences

by

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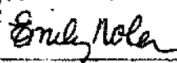
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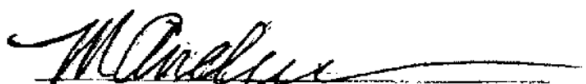
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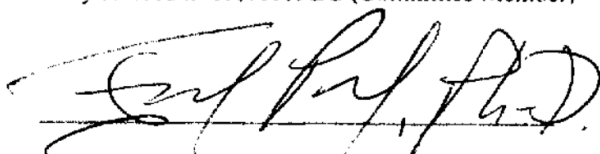
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Date

Abstract

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The purpose of this research study was twofold: (a) to understand obsessive–compulsive disorder (OCD) through the experiences and perspectives of individuals who live with it and (b) to assess students' and clinicians' knowledge of OCD and determine the effects of a brief video on OCD. There is limited public awareness of the lived experience of OCD, which is implicated in the long wait times that clients experience between symptom onset and accurate diagnosis. This lack of mental health literacy is one of many barriers; others include stigma and systemic issues such as racism. A phased mixed-methods approach was utilized to illuminate the phenomenon of OCD through audio-recorded interviews, artworks, and writings of people who agreed to share their experiences anonymously. These findings were condensed to a short film and shared with a convenience sample ($N = 74$) of graduate counseling and art therapy students and mental health clinicians via a nationwide survey, which assessed knowledge of OCD before and after viewing the film. The study produced three key findings: (a) people with OCD experience many covert symptoms that are not visible to the public (e.g., guilt, shame, taboo intrusive thoughts, and negative interactions with health care providers), (b) graduate students and mental health clinicians may have general awareness of stereotypical or overt symptoms of OCD (e.g., arranging or ordering objects, cleaning, etc.) but lack of knowledge of covert symptoms, and (c) exposure to narratives of people with OCD through a brief film greatly increased understanding and empathy for those who have this disorder.

Keywords: obsessive–compulsive disorder, OCD, art therapy, advocacy, mental health literacy, mixed-methods research

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To my partner Dylan, my family, and friends who have all sacrificed while I have been immersed in this journey, thank you.

Dedication

I dedicate this dissertation to all my clients with OCD. You have taught me so much.

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CHAPTER 1: INTRODUCTION

During a typical day of work in my private practice I see many patients who are living with obsessive–compulsive disorder (OCD) and related disorders. I specialize in treating OCD and related conditions; having advanced training and many years of experience I have seen hundreds if not a thousand or more people with OCD. To illustrate examples of typical clients I see, the following will provide two contrasting vignettes.

One day at my private practice I meet "Sarah," a young woman. I greet her and welcome her into my office. As we sit down, she begins to discuss her symptoms and becomes visibly upset. She cries and says she's afraid to tell me this, but she is worried she may be a pedophile. Sarah goes on to say that she has recurrent thoughts and images of sexually abusing children, and that these thoughts have become so distressing that she has stopped visiting the young nieces and nephews whom she dearly loves. She worries that she even feels aroused by these thoughts and images, which causes her to spend hours scanning her body and analyzing these feelings. Earlier in life she worked as a nanny, but now there's nothing more tormenting than the mere sight of a child, despite her belief that she actually does care for children and her previous certainty that she would have her own someday. Something that used to be so assured now fills her with doubt and dread.

Sarah has done everything she can think of to try and make these thoughts stop, but she continues to worry, "What if these thoughts mean something? Worse, what if I actually like these thoughts? What if I really do want to hurt children? I just couldn't live with myself. There's a part of me that knows I don't like these thoughts, but if I'm having them, I must be a bad person, right?" She's quick to follow all of these comments with

self-assuring words that she would never act on these thoughts. When I ask how long she has experienced these feelings and worries, she says they've been around in some form as long as she can remember. When she was young she used to say prayers compulsively and seek reassurance in order to be certain nothing bad would happen to her family members. As she got a little older, she started to worry about her sexuality. She felt guilty for having relationships with men when she feared she could be gay. She needed certainty that she wasn't misrepresenting herself and felt confused because she knew she was heterosexual but couldn't shake her gnawing doubts. When I ask her more about her past experience with therapy she says she has been to four or five therapists, but none have provided any substantial relief.

Later in the day, I see "Katie," a client with whom I've been working for a few months. Katie sought therapy due to distressing, violent thoughts and images about killing her loved ones. Prior to therapy she avoided all situations that might have triggered these thoughts, such as using knives for cooking and reading violent news stories. Her biggest worry is that she will "snap," lose control, and act on her violent thoughts, thus stabbing her husband to death. She also has stopped driving due to her fear of losing control and hitting a pedestrian. Her mind loops around on these thoughts incessantly.

In addition to her violent thoughts, Katie often seeks reassurance, particularly around food. She will ask her husband repeatedly if foods have expired and if they are okay to eat, fearing that if she serves them, others will get sick and be harmed by her negligence. Thus, she has avoided cooking foods for others and, when she does, she excessively washes her hands and cleans the utensils throughout the process. Outside of

these times, Katie is not particularly neat and tidy, even describing herself as somewhat of a "slob." Despite having violent thoughts and fears of harming people, for years she never thought she could have OCD because she was messy and didn't fit the stereotype. Although her thoughts are different from Sarah's, she too feels she must be a bad person due to the mere existence of her violent thoughts, leading to people-pleasing behaviors and excessive kindness to others to atone for these "bad" thoughts.

Sarah's and Katie's stories, although fictionalized representations of many clients I've treated, are not unique. These are stories I've heard countless times during the 10 years I've been working as an art therapist with people who have OCD. However, this disorder, which affects millions of people worldwide, commonly goes undiagnosed and untreated. Statistically, people with OCD who live in the United States experience an 11-year waiting period between symptom presentation and receiving effective treatment, if they even receive treatment at all (Pinto et al., 2006). Another U.S.-based study identified an average 14-year waiting period, with clients age 50 and older waiting an average of nearly 26 years to be treated (Cullen et al., 2008). These statistics bear out in my practice as well: The overwhelming majority of my clients report having had symptoms of OCD since childhood but are receiving effective treatment for the first time in their adulthood—sometimes in middle age or later. At best, clients may suffer a year or two before finding effective treatment. At worst, they may be tormented for decades by OCD symptoms or take their own life in order to find relief.

As with many mental health conditions, people with OCD may experience stigma, shame, and racial discrimination, all of which impact their ability to seek and find help. For example, in cases like Sarah's, the sensitive and taboo nature of her symptoms make

it especially difficult to reach out to a therapist. This can be compounded by fear of the clinician's duty to report potential child abuse. Additional barriers are unique to OCD. Partly due to stereotypes and inaccurate perceptions, OCD is widely misunderstood and often minimized by the general public and health care practitioners. This lack of understanding and knowledge leads to high rates of misdiagnosis and potentially harmful, ineffective treatments such as unnecessary involuntary hospitalization, psychodynamic therapy, and medications that are contraindicated. All the while, people with OCD may lose hope as they try numerous treatments without benefitting from them.

There is also the unique challenge of finding appropriately trained providers. Although considered to be a chronic condition (i.e., persistent and long-lasting), OCD is treatable. The most common treatment is known as exposure and response prevention, or exposure therapy, which is sometimes also used in conjunction with medications. This type of treatment requires specialized training that a mental health care professional may not have, especially in rural areas where there are fewer providers. Even when therapists have knowledge of exposure therapy, their biases and negative perceptions about it may prevent its use.

People with OCD face many barriers to treatment, but the issue of primary concern for this research study is the prevailing lack of public awareness and accurate perceptions of OCD in the U.S and elsewhere. It is my position that sharing one's lived experience is an effective way to increase another's understanding. Furthermore, I assert that people with OCD are the most well equipped to share knowledge of OCD based on their own experience. Thus, my study had two aims: (a) to understand obsessive–compulsive disorder through the experiences and perspectives of individuals who live

with it and (b) to share these experiences in ways that may increase public awareness and reduce barriers to accessing OCD treatment. I anticipated that if people with OCD shared their experiences anonymously through writing, artwork, and interviews, the reality of OCD would be elucidated. When shared with the public, and especially with physicians, mental health clinicians, and graduate counseling and art therapy students, knowledge and perceptions of OCD may be bridged, with improved access to care as one potential outcome.

In Chapter 2, I review the literature to identify and explicate the numerous barriers that exist for people with OCD who are seeking treatment. In addition, to understand the impediments to treatment, I provide background and contextual information surrounding OCD, including its definition and treatment. I also discuss the literature on skills required of professionals and argue for why art therapists may be uniquely situated to work with this population. Lastly, I discuss approaches to educate the public about OCD, with an emphasis on art-based methods to increase public awareness and empathy.

In Chapter 3, I provide an explanation and rationale for the research methods used to complete this study, specifically that of a mixed-methods study to produce both qualitative and quantitative results to address the research questions. This chapter also provides information on validity and ethical concerns. Then, in Chapter 4 I present the study findings and in Chapter 5 I discuss the implications of the results and draw conclusions on the potential impact of this research.

CHAPTER 2: LITERATURE REVIEW

This chapter provides a review of the literature of topics relevant to my research study. First, I will define OCD and present a history of OCD and its treatment. Then I will explore barriers to treatment, to illuminate the numerous factors that contribute to long delays between symptom onset and diagnosis. Specific information will be discussed related to inaccurate perceptions of OCD in social media, the general public, and health care providers and how this lack of awareness is an additional barrier to those with OCD seeking help, as this is a primary area of concern with my research. I also will explore methods of increasing knowledge about mental health conditions, specifically arts-based methods. This information provides context for my study to further understand what health care providers know about OCD and how to best educate them about the experience of OCD.

Obsessive–Compulsive Disorder

Definition and Prevalence

OCD is a mental health condition characterized by both compulsive behaviors and obsessions that a person experiences intensely and feels unable to control (Reed, 1985). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) defined "obsessions" as "recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted" (p. 235). For example, one person could be fearful of contracting a disease such as HIV/AIDS and another might obsess over fears of engaging in pedophilia, as in the case vignette about Sarah. Other examples of obsessions include anxiety-provoking thoughts about germs or contamination, urges to stab someone, or images of violence. "Compulsions" are defined

as "repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to the rules that must be applied rigidly" (APA, 2013, p. 235). A person, thus, attempts to suppress or control the intrusive thought with a behavior, like repeatedly counting backward from 100 to 1.

Obsessions that are *reactive* in nature tend to occur as a result of a specific trigger or external stimulus, such as touching or seeing something dirty or making a mistake. In contrast, *autogenous* obsessions often occur without any direct stimuli. Such obsessions often take the form of taboo thoughts that may be sexual, aggressive, or immoral in nature. These thoughts may appear "out of the blue" without any particular cause, which can create significant distress in the belief that these thoughts must have some meaning. Individuals with these obsessions often believe their thoughts pose a threat to their moral character (Lee & Kwon, 2003). For example, a person who fears harming a child may worry that the mere existence of such a thought must mean that they are a bad person or that they must actually desire to harm a child, when in fact such thoughts and fears are the opposite of the person's true desires or nature. Obsessions are understood to be ego-dystonic, meaning they are in opposition to one's desires and incongruent with one's self-concept.

Compulsions come in many forms and vary from person to person but occur in all people with OCD. Compulsive rituals function as strategies for either reducing the anxiety a person feels about their obsessions or preventing their bad effects from occurring in the future. For example, a person with contamination obsessions may engage in excessive handwashing and showering, seek reassurance from loved ones that items offered to them are clean, and avoid anything that could be contaminated. In contrast to

these outward compulsions, many people live with mental compulsions that may not be visible to an observer. For example, someone with violent obsessions may utilize mental attempts to block or suppress their thoughts and ruminate about their obsessions. They may engage in significant avoidance behaviors, such as keeping away from knives, staying away from and avoiding affection with loved ones out of fear that they otherwise may harm them, and steering clear of movies or news stories that could trigger violent and distressing thoughts.

Many people with OCD share similar compulsions but have different obsessions. For example, someone with contamination obsessions might avoid contact with loved ones due to fears that they will get sick, whereas a person with aggressive obsessions also might avoid their loved ones, but out of fear that they might hurt them. In both cases, compulsions are deployed as a strategy to reduce distress and gain certainty that something bad will not happen (e.g., "If I avoid my loved ones I won't get sick" or "If I avoid my loved ones I won't hurt them").

In all cases, people feel compelled to perform their compulsions because they perceive that a compulsive behavior will reduce their distress, provide a sense of certainty, stop their obsessions, prevent something bad from happening, and/or keep themselves or their loved ones safe. However, compulsions create a rebound effect, ultimately creating more obsessions and therefore more compulsions to control them. This cycle of obsessions and compulsions is tormenting, and although most people with OCD have the insight to recognize its illogical nature, they are helpless to stop it because of the high levels of fear they experience.

The cycle of obsessions and compulsions is time consuming; it may take an hour or more each day just to complete each ritual, causing significant distress and impairment in daily life functioning (APA, 2013). OCD often impacts one's social relationships, ability to work, and home management (Ruscio et al., 2010). The condition also tends to be chronic and may wax and wane in severity, although it typically deteriorates over time without appropriate treatment (Abramowitz, 2006). It is estimated that 1–3% of the world's population has experienced OCD in their lifetime (Ruscio et al., 2010), making it the fourth most common mental health condition, impacting hundreds of millions of people around the world.

The content of a person's obsessions and subsequent compulsions are idiosyncratic for that individual. Because the disorder is heterogeneous, symptoms vary considerably across individuals and within individuals over time. Although over 80% of people with OCD have symptoms in multiple categories, they commonly have one theme that is particularly distressing (Williams et al., 2013), which is why OCD is often categorized by type of primary obsession. Grant (2014) identified these common categories as follows:

- contamination (e.g., fear of being contaminated or contaminating others by germs, infections, environmental factors, and/or by "bad" or immoral people)
- sexual (e.g., fears of incest, molestation, homosexuality, engaging in pedophilia, or acting inappropriately toward others)
- religious/scrupulosity (e.g., concerns about being morally perfect or fears of blasphemy and/or eternal damnation)

- aggressive/harm (e.g., fear of harming self or others [often family members, children, or "hit and run" pedestrians] or frequent violent images of harming people that may include postpartum OCD, which typically manifests as intrusive thoughts of harming one's infant)

- control-related (e.g., fears of making inappropriate comments in public or through email, text, and phone communication)

- pathological doubt (e.g., worries about doing things incorrectly or doubt about common daily activities, such as leaving the stove on, locking the doors, etc.)

- superstitious (e.g., fears of "bad" numbers, colors, words, etc., or feeling responsible for a tragedy that might occur because specific actions weren't taken)

- symmetry and exactness (e.g., needing to do things in a balanced or even manner, often seeking a "just right" feeling)

Among these categories, the symptoms most commonly associated with OCD are symmetry and contamination; however, the actual range of obsessional themes extends far beyond these categories. In fact, it is estimated that contamination obsessions may only account for 25% of OCD cases in the United States (Ruscio et al., 2010; Williams et al., 2013). Rusio et al. (2010) asserted that approximately 80% of people with OCD engage in checking rituals (e.g., checking locks or appliances, mentally body scanning for feelings of arousal, etc.), which are most typically correlated with aggressive/harming, pathological doubt, and sexual obsessions. Sexual obsessions, including fears of engaging in pedophilia, have been reported by 25% of people with OCD. However, due to shame, stigma, and concealment of symptoms, it is likely that the prevalence is actually much higher (Bruce et al., 2018).

Of particular interest to this study is the concept of obsessional OCD, sometimes referred to as "pure O". This type of OCD generally refers to those whose primary symptom is a barrage of unwanted obsessions that are sexual, aggressive, and/or religious in nature and who generally have few, if any, observable compulsions (Williams et al., 2011). Although previously believed to have no accompanying compulsions (Baer, 1994), in a study that Williams et al. (2011) conducted with participants with OCD ($N =$ 201), all participants reported having compulsions. Complicating this matter is the issue of mental compulsions, which may include repeating words or prayers mentally, reviewing thoughts or actions, and providing oneself reassurance, as a few examples. These symptoms are invisible, and those who are affected by them may be unaware that these mental behaviors function as compulsions, thus complicating diagnosis as clinicians cannot observe these behaviors and their clients may not discuss them. Although it seems likely that all people with OCD engage in some type of compulsive acts, it would be incorrect to assume these acts are always observable.

The distinction between OCD and the diagnosis of obsessive–compulsive personality disorder (OCPD) is also worth mentioning. Although they share similarities in name, the key features of OCPD vary significantly from those of OCD. The key features of OCPD include excessive preoccupation with details, order and organization, excessive devotion to work and productivity, perfectionism, stubbornness and rigidity, among others (APA, 2013). Notably absent in OCPD is the existence of obsessions and compulsions. This is in contrast to people with OCD whose primary symptoms are unwanted thoughts and subsequent actions done to alleviate discomfort from these thoughts. One stereotype of someone with OCD is a rigid, controlling person who may be

inflexible in their ideas and ways of being. Although labeled as OCD, it may be more accurate to identify these characteristics with OCPD. Thus, inaccurate stereotypes of OCD and misdiagnosis prevail, which will be discussed in depth below. However, in exploring the convergence of symptoms between OCPD and OCD, Eisen et al. (2006) found higher rates of hoarding, perfectionism, and preoccupation with details among people with OCD as compared to those without OCD, all symptoms which correlate with OCPD and provide context for the similarity in their diagnostic labels. Other symptoms of OCPD such as rigidity, miserliness, and excessive devotion to work among others did not differ significantly among people with OCD and people without OCD. In their study, 8% ($n = 53$) of the sample size met diagnostic criteria for both OCPD and OCD, underscoring the need for thorough and accurate diagnostic assessment.

Given the socially taboo and alarming nature of some obsessions (e.g., fears of engaging in pedophilia, violent imagery of harming infants, etc.), it is important to note that there is no evidence that people with OCD actually act on these fears. However, people with OCD may be unnecessarily subjected to scrutiny, involuntary hospitalization, or mandated reporting requirements, often due in part to a clinician's discomfort and uncertainty. As Rachman and de Silva (1978) found in their classic study comparing intrusive thoughts of those with OCD to a control sample of people without OCD, the obsessions occurred in both groups and contained similar content. Thus, the mere existence of taboo thoughts is not sufficient evidence to suggest someone will act on these thoughts. For people with OCD, "such intrusions are unacceptable and ego-dystonic, and the person is no more likely to act on their intrusions than a person with height phobia is to jump off a tall building" (Veale et al., 2009, p. 333). In contrast, other

people with mental illness or antisocial personalities who do act on violent thoughts or urges find these thoughts pleasurable, and although they may be fearful of being caught, they do not experience fear and intense avoidance with their thoughts and urges (Marshall & Langton, 2005). Understanding that such thoughts are intrusive, unwanted, and directly against the character of people with OCD, as well as recognizing that those who experience them go to great lengths to avoid these thoughts, is imperative for accurate diagnosis and for understanding why OCD creates so much distress. Thus, a clinician with expertise in OCD can accurately distinguish between those experiencing unwanted OCD intrusions and those who are actually at risk of harming others.

Beyond the obsessions and compulsions, there are often core beliefs that are unique to OCD. For example, many people with OCD believe they are bad people because they have "bad" thoughts. Despite any evidence that their distressing thoughts are desirable or that they will act on them, people with OCD tend to believe that the mere existence of the thought makes them a morally bad person. Those who have pedophilia-themed OCD in particular often believe they should be punished for having these thoughts (Bruce et al., 2018). Relatedly, the Obsessive Compulsive Cognitions Working Group (1997) identified six belief domains that are persistent and unique to OCD. These domains include inflated responsibility, over-importance of thoughts, belief in the need to control one's thoughts, overestimating threats, intolerance of uncertainty, and perfectionism. As will be discussed later, it is important for clinicians to expect that their clients with OCD may have these beliefs and to become adept at helping clients see them as part of their OCD.

Etiology of OCD and Advances in Research

Historical Understandings of OCD

The current Eurocentric understanding of OCD has evolved and developed over hundreds of years. Centuries ago people who today likely would be identified as having OCD were thought to be possessed by outside forces and treated with exorcism by religious authorities or by traditional folk healers who would rid the person of invading influences (Jenike, 1983; Salzman & Thaler, 1981). In Freud's conceptualization of OCD, he espoused the belief that OCD symptomology was a result of unconscious psychosexual impulses and one's failure to individuate from one's mother (as cited in Jenike, 1983). Contemporaries of Freud, such as Sandor Rado, espoused the theory that OCD was the result of repressed rage, whereas others believed insecurity and helplessness were the cause (Salzman & Thaler, 1981). Psychodynamic approaches, aimed at unearthing hidden motivations for thoughts and actions, were the treatment of choice despite little improvement experienced by those being treated (Salzman & Thaler, 1981). Another theory, espoused by Janet (Jenike, 1983), promoted the idea that OCD arose from mental fatigue that caused a lack of control over one's thoughts and actions. Although knowledge and understanding of OCD has changed, there is still much we do not know about this condition.

In contrast to the Eurocentric view, OCD is often perceived and treated differently in Indigenous cultures, in Asia, and in Africa. For example, treatment of severe mental health conditions in India often includes interventions such as meditation, relaxation, and waiting for one's situation to change (Viswanath & Chaturvedi, 2012). In Kenya, OCD is

often believed to be caused by witchcraft, and people with OCD utilize traditional healers as the primary treatment modality (Williams, Chapman, et al., 2017).

Although similar symptoms of OCD are noted across cultures (Williams, Chapman, et al., 2017), manifestations and understandings of OCD may be culture-bound. For instance, there are higher incidences of contamination OCD in India, possibly due to the importance and practice of purification and cleansing rituals within the culture (Nicolini et al., 2017). Additionally, some patients in India may attribute their OCD to supernatural causes (Grover et al., 2014). Likewise, there are higher rates of religious/scrupulosity OCD among highly religious individuals including Protestants, Catholics, Muslims, and Orthodox Jews (Abramowitz et al., 2004; Nicolini et al., 2017). However, depending on one's values, OCD behaviors such as excessive prayer, scripture reading, cleansing rituals, and/or piety may be praised and considered desirable within one's culture.

Current Theories of Etiology

In the modern era of OCD treatment within the United States, the psychoanalytic theories described above have been disregarded in favor of theories related to genetics, neurobiology, and cognitive behavioral etiology models. Research over the last 60 years suggests that there are likely multiple factors that contribute to the symptomatic expression of OCD, as one model of etiology cannot explain all cases of OCD.

Neurobiological theories of OCD etiology can be categorized in relation to neurocircuitry, neuroanatomical structures, and neurochemical markers, all of which may be implicated in OCD. The neurocircuitry hypothesis suggests that there may be abnormal information processing occurring among the cortico-striatal-thalamo-cortical

circuitry within the brain (Pauls et al., 2014; Rosenberg et al., 2005). Through a review of the literature, Pauls et al. (2014) posited that people with OCD may have a lower threshold for activation of this pathway, which results in excessive brain activity and, specifically, exaggerated concerns about danger.

Researchers have utilized brain imaging to identify several areas of the brain that may be impacted by and/or responsible for the symptoms of OCD. The basal ganglia, which is responsible for filtering and suppressing cognitive input, as well as the prefrontal cortex and thalamus, depict increased volume in people with OCD when compared to people in control groups (Rosenberg et al., 2005). Additionally, the anterior cingulate cortex, which is likely responsible for evaluating high conflict situations, has been implicated in OCD (Pauls et al., 2014). A neuroimaging study by Nakao et al. (2014) suggested that involvement of some areas of the brain may be dependent upon the presenting types of OCD symptoms (e.g., checking or cleaning). This theory implies that there is no universal neurological basis for OCD but rather an individual's symptomology may dictate which areas of the brain are impacted.

Lastly, the neurochemical model of OCD suggests that neural markers such as serotonin, N-acetylaspartate, and glutamate, among others, may all play a role in OCD (Rosenberg et al., 2005). Glutamate has received particular interest as an area of study as it is an amino acid that is believed to be the brain's primary excitatory neurotransmitter, and a glutamate imbalance may play a role in OCD (Pittenger, 2015). However, due to the complexity of this amino acid it is too simplistic to state that glutamate is either excessive or reduced in people with OCD; therefore, it cannot be addressed in a one-dimensional way by simply increasing one's glutamate intake by medication (Pittenger,

2015). Of the neurobiological theories of OCD, the neurochemical model is perhaps the most uncertain in terms of its connection to the expression of OCD and therefore it is an area in need of more research (Pauls et al., 2014).

From reviews of the research literature conducted by Pauls et al. (2014) and more recently by Purty et al. (2019) on the genetics of OCD, there does appear to be evidence of a strong link between family members and children with OCD, particularly among first-degree relatives. A meta-review of studies on twins (Purty et al., 2019), which provide stronger evidence that a condition is genetic compared to familial studies, found that it does appear that genetic factors contribute to OCD. Among twins the heritability rate is estimated to be between 40% and 65% (Purty et al., 2019).

Despite the connections among family members and twins this correlation does not necessarily mean OCD is genetic and certainly does not mean all cases of OCD are genetic; instead, OCD may exist due to environmental factors and learned behaviors that exist among families (Pauls et al., 2014). In some cases, family members may teach or model OCD behaviors and beliefs to children, such as specific washing rituals or the need to check locks and appliances around the house to ensure safety. Additionally, it is possible that a person who is genetically predisposed to OCD may live in a family environment that encourages avoidance of anxiety, thus reinforcing the development of OCD. Therefore, it seems likely that both environmental factors and genetics contribute to OCD.

Cognitive behavioral models, including learning theory, provide another avenue for understanding the development and maintenance of OCD symptoms. According to the behavioral model of etiology for OCD, the condition develops as a person learns that they

can use rituals to reduce discomfort. Learning theory, in the context of OCD, proposes that people with OCD learn to associate their intrusive thoughts with anxiety and then learn to reduce their discomfort, albeit temporarily, through avoidance or other compulsive behaviors. This behavior provides a feedback loop in which compulsive behaviors are reinforced while the obsessions remain (Shafran, 2005). Additionally, as discussed above, social learning may play a role in OCD as family members or clergy may instill beliefs about danger or the need to be excessively responsible or cautious (Mineka & Zinbarg, 2006).

Cognitive behavioral models of etiology espouse that there are beliefs and ways of appraising thoughts that are unique to individuals with OCD and that these types of thoughts are central to the development of OCD (Shafran, 2005). For example, although nearly everyone experiences intrusive thoughts, people with OCD evaluate these thoughts to be repugnant and make attempts to suppress or ignore them. Additional cognitive distortions such as thought-action fusion (the idea that a having a thought is equivalent to acting on the thought) and over-responsibility are also prevalent among those with OCD. Thus, it is believed that cognitive processes play a role in the development and exacerbation of OCD symptoms.

Advances in Research

As noted, there are still many unanswered questions about OCD that would contribute to our understanding of the causes and improve treatment for those with the condition. Recently, the International OCD Foundation has supported large-scale research studies in neurobiology and genetics to refine scientific understanding of the etiology of OCD (International OCD Foundation, n.d.). McKay (2018) noted that

research on OCD has been rapidly expanding in recent decades, citing the tremendous rate of peer-reviewed publications and the recent development of the first academic journal on OCD, *Journal of Obsessive-Compulsive and Related Disorders*, as examples.

This proliferation of research would suggest a corresponding increase in awareness and improved ability to treat OCD among clinicians. However, it appears that there continues to be a significant gap between findings from researchers and frontline providers of treatment (McKay, 2018). It is apparent that with additional research, efforts will need to be made to make research findings accessible to clinicians and people with OCD.

History and Current Treatment of OCD

Development of Cognitive Behavioral Therapy

Prior to the development of a counseling theory known as cognitive behavioral therapy (CBT), OCD was primarily treated using psychodynamic and psychoanalytic therapies. These approaches produced little to no improvement in symptoms and therefore OCD was seen as a treatment-resistant disorder (Abramowitz, 2006; Foa, 2010). In a review of the research on the treatment of OCD between 1953 and 1978, Salzman and Thaler (1981) found that psychodynamic therapy did not demonstrate clinical benefit. Although a psychodynamic approach features some aspects that overlap with CBT, such as the focus on a strong therapeutic alliance between therapist and client, the traditional focus of psychodynamic therapy on past traumas, interpersonal relationships, and strong emphasis on verbal processing does not appear to be effective for relief of OCD (Salman & Thaler, 1981). In a randomized controlled trial conducted by Maina et al. (2010) with adults with OCD, there was no significant difference between the group receiving

psychodynamic therapy in combination with medication and the group who only received medication. Reviewing the past, exploring unconscious drivers of behavior, and analyzing one's feelings and beliefs may actually cause harm in people with OCD when these inward-focused analyses are exactly the compulsions that exacerbate OCD.

In contrast to psychodynamic approaches, CBT focuses on the interaction between thoughts, behaviors, and feelings, and thereby holds three central tenets: thoughts affect behavior, thinking can be monitored and altered, and behavior change can occur by changing one's thinking (Dozois et al., 2019). CBT is often directive and experiential, meaning that clients learn to test out assumptions or beliefs with actual behaviors or homework assignments to determine their effects, as opposed to merely talking about their problems. Additionally, CBT is often focused on the here and now, in contrast to other approaches that explore one's past.

CBT is a theory that includes numerous strategies and interventions, and although many of these strategies rely heavily on the importance of changing one's thinking, there are other interventions that rely on behavior change. Mahoney and Arnkoff (1978) further divided CBT interventions into three subtypes: cognitive restructuring, coping skills therapies, and problem-solving. Coping skills therapies provide the client with a "toolbox" of skills designed to help manage stressful situations. Problem-solving techniques encourage clients to become their own therapist by teaching a variety of behavioral responses to help them manage difficult situations.

Cognitive restructuring assumes that one's maladaptive thoughts are the cause for unhelpful behavior and therefore distress. If one can restructure or challenge one's thinking, this may lead to a chain reaction of behavior change and improvement in mood.

In the case of OCD, many people have the thought that they are a bad person and must be punished because of their repugnant thoughts. This thought creates distress and often leads to self-punishing behaviors. Therefore, one aspect of treatment may be to challenge and reframe this thought, thus leading to more compassionate self-care. As an example, if someone with OCD has the belief, "I should punish myself because I have bad thoughts," this belief could be reframed into, "Everyone has intrusive thoughts. I can choose to be compassionate to myself instead of punishing myself." As an additional step, clients may be asked to practice acts of self-compassion to further challenge the original belief that they should punish themselves.

CBT and OCD

Cognitive behavioral therapy approaches to address OCD can be traced to the 1950s, when Solomon (as cited in Solomon et al., 1953) began testing the tenets of behaviorism with studies of dogs that learned to fear certain stimuli despite the fact that the stimuli actually posed little to no harm; they reduced their fear through avoidance and compulsive behaviors. This finding established behavioral evidence of a pattern that is also seen in humans with OCD who suffer from fear associated with a stimulus (e.g., intrusive thoughts, contaminated surfaces, etc.) and use compulsive behaviors (e.g., handwashing, seeking reassurance, avoidance, etc.) to reduce anxiety associated with the stimulus. Meyer (1966) drew from Solomon et al. (1953) and other behavioral studies as the basis for experimenting with a technique that came to be known as exposure therapy, leading him to become the first researcher to demonstrate significant success in treating OCD (Foa, 2010).

Exposure therapy (or exposure and response prevention, often abbreviated as ERP, E/RP, or EX/RP) is a subtype of CBT that focuses on addressing a feared stimulus through gradual exposure to it. In contrast to many CBT techniques that rely heavily on challenging thoughts, ERP utilizes a client's own behavioral experiments focused on going toward discomfort related to their obsessions and reducing the compulsions that accompany OCD. In this therapy clients come toe-to-toe with their fears with the aim of gaining new learning about them, which challenges their assumptions that the feared stimuli will be intolerable or threatening (Richard et al., 2006). An exposure is an invitation to test assumptions (e.g., "If I don't check the stove, I'll burn the house down and my loved ones will die") in order to promote new learning (e.g., "I didn't check the stove, and nothing bad happened!").

As an example, someone with an obsession about harming a loved one might complete an exposure to hold a knife and think about killing a loved one. The therapist often guides the client through this process to ensure the client is not ritualizing (i.e., not doing anything to avoid or alleviate their discomfort) and to assist them in focusing on their bodily sensations and feelings. Through repetition of this process the client learns that their discomfort is tolerable when they go directly toward their fear and also often learns that nothing bad happens when they face their fear. During this process a client may experience habituation, which is the natural process of anxiety reduction that occurs when one stays within an uncomfortable situation. When a person is engaged in the OCD cycle, habituation is interrupted by rituals, and therefore the person doesn't have the experience of allowing the anxiety to subside on its own without rituals. Even if habituation is not achieved, a client can still benefit from ERP by learning that they can

tolerate the distress associated with their obsessions and that compulsions are unnecessary.

As an experiential type of therapy, there are generally two types of exposures: in vivo and imaginal. During in vivo exposure, a person actively engages in an exposure in real life (e.g., holding a contaminated object), whereas during imaginal exposure a person imagines their fear, typically through writing and imagery (e.g., writing a story about harming a loved one). The process of engaging in active experiments and experiencing one's fear are critical elements of exposure therapy and key distinctions from traditional talk therapies; that is, the emphasis is on experiential learning as opposed to verbal processing. Exposure therapy is unique in that clients learn by doing and experiencing, rather than by talking. The use of ERP as a form of experiential therapy and connections to art therapy will be discussed more in depth below.

Today, ERP often is used in conjunction with more traditional cognitive therapy or cognitive behavioral therapy techniques, such as identifying and challenging cognitive distortions (McKay et al., 2015). Nearly all people with OCD experience one or more of the common categories of distorted beliefs. For example, they may believe they bear excessive responsibility for events that occur; that is, they believe they have a unique ability to cause and/or prevent tragedies. Using the previous example, a person might believe they would be responsible for a tragedy because they didn't check the stove. However, they also would have little to no concern that their spouse might commit the same act. Thus, they believe there is something unique about them that could cause a tragedy, which requires a unique ability to prevent it. Additionally, because people with OCD tend to place an over-importance on their thoughts (e.g., "If I had this thought, it

must mean something"), they often believe they need to control their thoughts, despite any evidence that such control of one's thoughts is necessary, helpful, or even possible (Abramowitz, 2006).

Often used alone or in combination with ERP, medications have shown some efficacy in reducing symptoms of OCD. Antidepressants known as tricyclics and selective serotonin reuptake inhibitors have been studied in randomized controlled trials and approved in the United States as effective treatments for OCD (Foa et al., 2005; Franklin & Foa, 2011). Although there is some evidence that these medications may be helpful, the combination of medication and ERP has not been shown to be superior to ERP alone (Foa et al., 2005; Franklin & Foa, 2011; van Balkom et al., 1998). However, in certain situations medications have benefits over ERP in that they are often easily accessible, affordable, and available when specialized treatment providers may not be accessible.

Recently, clinicians also have been looking at the potential benefits of integrating mindfulness into treatment of OCD (Fairfax, 2008; Hershfield & Corboy, 2013) and third-wave CBT variants such as acceptance and commitment therapy and dialectical behavior therapy (Twohig et al., 2015). In many of these treatments, clients are encouraged to be observers of their thoughts without reacting to them, thus interrupting the cycle of obsession and compulsion. Family therapy is often incorporated as well, in order to understand and dismantle the ways in which families have accommodated a loved one's OCD (Steketee & Van Noppen, 2004).

In the case of acceptance and commitment therapy, an important concept for OCD treatment is that of experiential or emotional avoidance, which describes the

unwillingness to experience distressing thoughts and emotions (Abramowitz et al., 2009).

This approach posits that it is not the existence of distressing thoughts or emotions that is

problematic; rather, it is one's response to them that may create harm. Similarly, in

dialectical behavior therapy, a skills-based approach is used to help clients build distress

tolerance skills and mindfulness, both of which are used to help clients sit with

distressing feelings and thoughts (Fairfax, 2008).

Although OCD treatment continues to expand and incorporate additional

modalities, exposure therapy is often described as the "gold standard" treatment for

obsessive–compulsive disorder because of research evidence that has shown it to be the

most effective psychological treatment for the disorder with regards to reduction of

symptoms and impairment (Abramowitz & Larsen, 2006; APA, 2007; Koran & Simpson,

2013; Ponniah et al., 2013). Ponniah et al. (2013) arrived at this conclusion through a

review of randomized controlled trials that compared treatments for OCD. Among 31

such studies, ERP was effective in reducing symptoms compared to waiting list controls

and compared to other treatments such as anxiety management and relaxation training,

among others. In several randomized controlled trials, exposure therapy was shown to be

more effective than medication in reducing symptoms and maintaining gains (Foa et al.,

2005; van Balkom et al., 1998).

However, despite the success of ERP, it is not effective for all individuals with

OCD and can have notable attrition rates. In a meta-analysis of 21 randomized controlled

trials with ERP, Ong et al. (2016) estimated that ERP has an 18.7% attrition rate, which

includes treatment refusal and dropouts. Although this is a significant percentage, the

rates of attrition in the treatment of other mental health conditions are similar (e.g. major

depression, 17.5%; Cooper & Conklin, 2015; PTSD, 18.3%; Imel et al., 2013) which suggests that the attrition rate is not unique to ERP.

It is difficult to estimate how many people respond to evidenced-based treatments such as ERP and medication, in part due to the remarkable number of variables that must be considered (e.g., number of sessions, inconsistency in the delivery of ERP, therapist training and knowledge of ERP, comorbidity of OCD and other disorders, level of family accommodation, etc.). Although effective for many, ERP is not a panacea. It is estimated that 15–30% of people with OCD have treatment-refractory OCD, meaning they have not been responsive to treatments such as medication or ERP (Foa et al., 2005; McKay et al., 2015). For people with severe treatment-refractory OCD who have exhausted psychological and pharmacological treatment options, a surgical intervention known as deep brain stimulation is often recommended and can reduce symptomology for some people (Greenberg et al., 2006). The high attrition and response rates to ERP warrants additional research to improve treatment options and outcomes.

Barriers to Effective Treatment

Significant barriers exist for people with OCD trying to receive effective and timely treatment. The primary focus of my research is to assist people with OCD by lowering treatment barriers and, in particular, by reducing stigma and misinformation about the disorder through professional and general public education. For people with OCD living in the United States, lengthy gaps between symptom presentation and receiving treatment have been found. Pinto et al. (2006) estimated that people with OCD wait an average of 11 years between symptom onset and receiving effective treatment. Cullen et al. (2008) found even longer wait times of an average of 14 years. In the latter

study, because the sample ($N = 602$) was predominantly White, the researchers suggested the results are not generalizable to other racial groups and that African Americans and other people of color may experience even longer wait times. In a rural Australian sample of clients with anxiety disorders and OCD, the wait time increased to an average of 18 years (Green et al., 2012). Moreover, in one study sample, only 30.9% of participants with severe OCD and 2.9% of participants with moderately severe OCD symptoms reported having received treatment that was specific to OCD (Ruscio et al., 2010).

As McKay (2018) noted, despite impressive advances in research surrounding OCD there is a paucity of providers and an unacceptable number of barriers to receiving effective treatment. Clearly, there is a need for information sharing across disciplines to reduce the wait time and help individuals with OCD find effective treatments sooner.

Mental Health Stigma

The origin of the word "stigma," from the Greek language, referred to a physical mark that identified a person as bad or immoral (Merriam-Webster, n.d.). In Goffman's (1963) seminal text on the subject, he described stigma as an "attribute that is deeply discrediting" in one of three forms: a physical attribute/disability, a mental issue or character flaw, or a "collective condition" as in race or religion (p. 3). Goffman espoused the idea that a society views people with one or more of these attributes as not fully human; this perception leads to overt and covert acts of discrimination toward stigmatized people.

People with mental health conditions may experience two types of stigma: anticipated and internalized (Fox et al., 2018). *Anticipated stigma* refers to the extent to which people with mental health conditions expect to be discriminated against or to

experience prejudice. *Internalized stigma* is the extent to which people have internalized, endorsed, and assumed or accepted the negative beliefs and feelings that their societies associate with their mental health condition (Fox et al., 2018). For example, from the case vignette presented at the start of this essay, Sarah likely experienced some form of anticipated stigma prior to beginning treatment because she knew she would need to discuss her intrusive thoughts with her therapist, leading to fear and shame about how she would be perceived. Sarah also experienced internalized stigma from having adopted societal beliefs that she was flawed, defective, or "crazy" because of her mental health condition. The experience of stigmatization is dehumanizing, often contributing to a delay in treatment and lower life expectancy in people with mental health conditions (Colton & Manderscheid, 2006; Fox et al., 2018).

As with many mental health conditions, people with OCD often experience stigma and shame about their symptoms. Glazier et al. (2015) estimated through online questionnaires that anywhere from 20% to over half of people with OCD have these experiences. According to a study conducted by Demet et al. (2010) on why people with OCD delay seeking treatment, people with OCD often cite shame and fear of stigmatization—with particular concern about the meanings of their intrusive thoughts— as a reason for delaying treatment. Additionally, Glazier et al. (2015) found that people with OCD who experience a high level of violent, sexual, or religious obsessions reported higher levels of shame and anxiety about how others thought of them compared to people with contamination or symmetry obsessions. Further, the very nature of OCD often contributes to internalized stigma. Because a key feature of OCD is the over-importance of thoughts, people who experience intrusive thoughts about themselves come to believe

they are inherently bad people. This message may be compounded and exacerbated by societal messages about mental illness, as well as by the often socially taboo content of their obsessions. For example, people with pedophilia-themed OCD must cope with both the stigma of having a mental health condition and the stigma of pedophilia, even though they are not pedophiles.

Stigmatization can also implicate family members. Family members of people with OCD may feel embarrassed by their loved one and thereby experience their own form of stigmatization. In one study, family members not only endorsed stigmatization but held the perception that they needed to conceal their family member's OCD (Stengler-Wenzke et al., 2004). Family members may also contribute to their loved one's stigmatization. In the study by Glazier et al. (2015) on the role of shame and stigmatization as barriers to treatment ($N = 164$), people with OCD reported fears of being criticized by family members or endorsed and accepted actual stigmatization from their family members. Family members may make jokes about the compulsions or criticize their loved one's behaviors. Thus, there can be a compelling motivation to conceal symptoms, causing further deterioration of functioning while delaying exposure to accurate information about OCD (Belloch et al., 2009).

Lack of Providers

As discussed above, effective treatment options for OCD include medications and a subset of CBT known as exposure therapy or exposure and response prevention. Despite these options, very few people actually receive these types of treatment, in part due to a lack of appropriately trained providers. O'Neill and Feusner (2015) cited the lack of providers as a significant external barrier for people with OCD. Reid et al. (2017)

identified that 48% of a sample of therapists ($N = 230$) treating youth with anxiety disorders reported lack of training as a primary barrier to providing ERP. Graduate counseling and psychology programs generally do not provide in-depth training on CBT or OCD because these programs are designed to provide general clinical training. OCD treatment is a clinical specialty in which clinicians typically receive specific training after graduation. It is possible that the lack of exposure to OCD in graduate school impacts students' decisions to pursue the specialty after graduation. In my own experience, I had not considered working with clients with OCD during my graduate training and was not aware of this clinical specialty until I began working at a specialized treatment center.

People who live in rural areas tend to face the most hardship in terms of access to mental health care in general and OCD treatment providers in particular. In a review of 18 research articles over the past 20 years, Jensen and Mendenhall (2018) found three main barriers to treatment in rural areas: inadequate availability of services, limited accessibility to these services, and low social acceptability for seeking services (p. 309). Additionally, providers in rural areas tend to be generalists rather than specialists in order to meet the diverse needs of their clientele and due to the lack of other providers and mental health services (Hastings & Cohn, 2013). As will be discussed below, it is important for therapists treating OCD to be specialists in this disorder, thus creating a paucity of OCD specialists in rural areas.

Therapists' Attitudes and Beliefs About ERP

Even when therapists have training and awareness of OCD and ERP, many are reluctant to utilize this treatment due to their own attitudes, biases, and beliefs (Deacon et al., 2013). Therapists may have unsubstantiated fears about exposure therapy, including

the belief that clients are too fragile to withstand its course of treatment and may

decompensate (Becker et al., 2004; McKay, 2018) or even that exposure therapy is

unethical (Olatunji et al., 2009). A study utilizing the Therapist Beliefs About Exposure

Scale (Deacon et al., 2013) identified that female therapists in the sample tended to have

higher rates of negative beliefs about ERP, resulting in more cautious delivery and

therefore less effective use of the treatment. The authors suggested that compared with

male therapists, female therapists may have negative attitudes toward ERP due higher

levels of empathic concern and the perception that ERP is stressful. In contrast, there

were fewer reservations among therapists who were men, younger, PhD-educated

psychologists, and/or self-described as anxiety specialists. Deacon et al. (2013)

hypothesized that therapists with less education may have different attitudes toward

evidence-based practices due to differences in training. Interestingly, these researchers

observed an increase in positive attitudes about ERP following a didactic training,

suggesting that more education and training about this modality may lead to more

effective delivery.

In a sample of U.S. therapists in private practice ($N = 257$) who treat youth with

OCD and other anxiety disorders, therapist-assisted in vivo exposure therapy was used

only 19% of the time (Reid et al., 2018). Negative attitudes toward ERP were a primary

reason that therapists did not utilize this approach. These attitudes included the fear that

clients are at risk of decompensating if they use ERP, that clients need coping skills in

order to manage the effects of ERP, and that most clients have difficulty tolerating the

distress that ERP provokes (Reid et al., 2018, p. 14).

Although utilizing a small sample size ($N = 43$), Bauer et al. (2017) surveyed art therapists about their attitudes toward evidenced-based practices that included CBT and ERP. All of the participants were alumni of the same school with a graduation date ranging between 1974 and 2014. Fifty-seven percent of participants said they had not received training in any evidenced-based practices during their graduate training. Among these, approximately 70% stated they had been trained in at least one evidenced-based practice after graduation; only five respondents reported using CBT and only one reported the use of ERP in their clinical practice. However, it is unclear how many of the participants had clients with OCD. Additional training and education of art therapists may help to reduce these biases and increase the likelihood that therapists will utilize evidence-based treatment options.

Race

Williams et al. (2012) noted that although OCD occurs in African Americans at the same rate as in the general population, they are vastly underrepresented in treatment centers and in research studies. In the authors' study examining unique barriers African Americans experience in receiving treatment and participating in research, participants identified the desire to see a counselor of the same race, higher fears of misdiagnosis or hospitalization compared to their White counterparts, and awareness of the history of medical abuses that African Americans have experienced in research and treatment. One such abuse is the notorious Tuskegee syphilis experiment, conducted by the U.S. Public Health Service between 1932 and 1972 on an unknowing sample of African American sharecroppers who had latent syphilis. This experiment is notable for its lack of informed consent for participants and because researchers knowingly failed to treat participants

who had syphilis after the availability and effectiveness of penicillin became known (Jones, 2008).

Fears of misdiagnosis and of being hospitalized against one's will are not unfounded either. In the United States, African American and Black Caribbean individuals have higher rates of inpatient hospitalization and are more likely to be diagnosed with psychotic disorders than their White counterparts, even after controlling for key social, clinical, and demographic factors (Snowden et al., 2009), suggesting the presence of bias among clinicians in how they diagnose and conceptualize treatment for these clients.

Williams et al. (2012) utilized questionnaires to compare barriers to treatment for African Americans with OCD ($n = 71$) compared to their European American counterparts ($n = 108$). The researchers observed barriers to treatment that were unique to African Americans, including not knowing where to find help and concerns about discrimination. The researchers noted that both groups endorsed concerns about insurance coverage, whether treatment would be successful, and stigma and shame at approximately the same rates (Williams et al., 2012, p. 559).

In a later study by Williams, Taylor, et al. (2017) that examined the impacts of racial discrimination among African American and Black Caribbean individuals with OCD, the authors concluded that the stress of racial discrimination directly affects the severity of individuals' obsessions and compulsions. The authors suggested that the mental energy required to process and manage discrimination may lead to mental fatigue, which depletes mental resources available to reduce OCD symptoms. Additionally, compulsions may be directly related to racial stereotypes or fears of discrimination. For

example, there is a higher prevalence of contamination concerns within this population, often manifesting as excessive washing, which could be understood as a reaction to racist stereotypes or fears of being perceived as unclean (Williams, Taylor, et al., 2017).

Willis and Neblett (2018) arrived at a similar conclusion: Stress from racial discrimination exacerbates OCD symptoms. This study, with a sample of 171 African American young adults who completed measures of racial discrimination, racial identity, and OCD symptoms distress, suggested that racial discrimination may be a risk factor that can lead to greater OCD symptoms. In addition, the more likely someone is to experience everyday racial discrimination, the less likely they are to receive treatment for their OCD, thus exacerbating their symptoms (Williams, Taylor, et al., 2017). As Himle et al. (2008) noted, service utilization for African American and Black Caribbean individuals is low, particularly with regards to the utilization of specialized treatment. Systemic barriers to treatment (e.g., income inequality) and low help-seeking behaviors are factors that may contribute to this finding (Himle et al., 2008).

Public Knowledge and Perceptions of OCD

Although the above barriers are significant and worthy of further investigation in their own right, I posit that a significant barrier to receiving effective treatment is the lack of accurate knowledge about OCD in the general public and among health providers. Current perceptions and stereotypes about OCD contribute to long wait times and unnecessary suffering. Thus, the primary focus of my study was to address this barrier by improving public education and awareness of OCD. The discussion below will detail the lack of understanding and knowledge of OCD among the general public, physicians, and

mental health clinicians and will also include a discussion of how OCD is portrayed in the media.

General Public's Knowledge of OCD

The ability to recognize, correctly identify, and understand issues related to psychiatric disorders is known as mental health literacy (Jorm, 2012). For OCD and many other mental health conditions, a lack of mental health literacy on the part of clinicians and the general public correlates with clients' symptoms going unrecognized and untreated (Coles et al., 2013). In their sample of 577 adults who participated in a telephone survey and were given a vignette of OCD symptoms, Coles et al. (2013) found that only approximately 33% were able to correctly label the disorder as OCD. The same sample recommended primary care physicians as the first referral source for seeking help, compared to professional counselors, who were only recommended at a rate of 3.4%. However, the authors also discussed how large public health campaigns, discussed below, have increased mental health literacy with other mental health conditions and therefore increased service utilization (Coles et al., 2013).

In a similar study with Spanish adolescents, approximately 72% of the participants were able to identify OCD when the vignette was focused on OCD symptoms, such as ordering items or producing symmetrical arrangement, but only 23.5% of the sample were able to correctly label the disorder as OCD when the symptoms included aggressive obsessions. The latter vignette was more likely to be labeled by participants as schizophrenia or depression (García-Soriano & Roncero, 2017). In a sample of 808 U.S. adults who were asked to define OCD, the most frequent replies identified stereotypical OCD traits such as perfectionism, eccentric personality, and

perseveration. None of the respondents identified other symptom dimensions of OCD, such as intrusive sexual or aggressive obsessions (Stewart et al., 2019).

As the above studies suggest, the general public may not be able recognize and understand OCD, which may present several barriers for people in need of care. Family members, teachers, and/or clergy are often the people who have early and direct contact with people with OCD, thus being in a position to help navigate the complicated terrain of mental health treatment. The data suggest that the general public is ill equipped to intervene, which may shift the burden of identifying the disorder and seeking treatment to the individual with OCD. People experiencing OCD symptoms may be no better at identifying the disorder and often believe they must conceal their symptoms due to the shame that is associated with OCD, thus contributing to delayed treatment.

Representations of OCD in the media may perpetuate inaccurate stereotypes and contribute to low mental health literacy regarding OCD. In Fennell and Boyd's (2013) qualitative study, people with OCD were asked to watch media containing characters with OCD (including the popular television show *Monk*), and the attitudes of many participants revealed a "stigma hierarchy" (p. 674), meaning that OCD is viewed less seriously than other mental health conditions due to the perception that OCD is a quirk or a joke. Fictional characters with OCD tend to be presented as eccentric or in a lighthearted manner, in contrast to the true nature of OCD, which often produces significant impairment and suffering. Additionally, participants felt that OCD is portrayed more like a personality trait than a legitimate mental health condition. This attitude may exist in part because mass media tend to show a limited range of OCD experiences, typically depicting stereotypical OCD behaviors such as cleaning and

hoarding and omitting symptoms such as aggressive or sexual obsessions. For those who may not know they have OCD, seeing an accurate representation of their experience may provide insight into their symptomology. It may also reduce isolation for people with OCD—both those who are diagnosed and those who are undiagnosed.

In contrast to Fennell and Boyd's (2013) study discussed above, which utilized fictional characters, Miller et al. (2015) found that viewers who watched reality television shows depicting real people with OCD revealed a modest increase in positive perceptions of exposure therapy compared to a control group of participants who watched another reality television show. Although these types of television programs may increase public awareness and perception about OCD and its treatment, they also run the risk of sensationalizing and exploiting vulnerable populations because the programs are developed for entertainment rather than public education. By disproportionately highlighting the distressing aspects of mental health conditions as opposed to showing people with OCD in broader contexts, these television shows may perpetuate stereotypes that people with mental health conditions are dramatic or unpredictable (Koh & Shrimpton, 2014).

A simple search within Instagram for #OCD produces over 1.5 million posts. Many of these posts are aimed at providing psychoeducation and support for people with OCD and their loved ones. However, many other posts perpetuate inaccurate stereotypes by displaying overly clean homes, organized closets, and objects lined up in a row. Similarly, the phrase "I'm so OCD" or "I'm a little OCD" is commonplace, suggesting that OCD is only a quirk and thus demonstrating a misunderstanding of the disorder. Pavelko and Myrick (2016) identified three components that occur in social media use

about OCD: oversimplification of the disorder, perception of decreased severity, and mockery. These components of trivialization undermine the reality of life with OCD. As one example, the focus on cleanliness or organized closets ignores the other half of the disorder of OCD: the distressing, intrusive thoughts that are invisible to someone outside the disorder. Additionally, organization and cleaning may only relate to a portion of people with OCD, as many others have symptoms of avoidance, reassurance seeking, checking, or other behaviors commonly associated with taboo thoughts.

Robinson et al. (2019) compared 13,000 tweets about five physical health conditions and five mental health conditions on Twitter, finding that OCD was the most trivialized of all conditions included in the study. The authors noted that stigmatization occurred for all of the health conditions studied but that the stigmatization and trivialization of OCD was depicted through specific methods including minimizing suffering, glamorizing the condition or viewing behavior associated with OCD as positive, and mockery.

Although social media may contribute to misunderstandings about OCD, for those living with the condition social media also can offer the opportunity to form networks and learn about the disorder. Online peer-to-peer support, often found in Facebook groups, on YouTube, or on other social media sites, can promote connectedness, reduce stigma, and provide hope (Naslund et al., 2016). Similarly, access to health information online (e.g., through Google searches, online forums, etc.) has altered the way many people learn about physical and mental health conditions. The process of seeking health information online may help patients to be better informed about their illness and connect with others experiencing similar symptoms (Tonsaker et al., 2014). People with OCD

who are embarrassed or fearful of their OCD symptoms may feel more comfortable finding health information online instead of discussing their concerns with a clinician in person. However, there may also be challenges to seeking health information online. One such challenge is that online health information is unregulated, meaning patients may rely on faulty information to make decisions about their health care, potentially leading to treatments that are ineffective or harmful (Tonsaker et al., 2014).

Primary Care Physicians' and Psychiatrists' Knowledge of OCD

It has become common today in the United States for people to seek mental health treatment through primary care physicians, with 32% of people in the United States relying on primary care as their sole source of mental health care (Glazier et al., 2014). This shift in seeking help is concerning because primary care physicians may not be any more informed about OCD than the general public. In a sample of 208 primary care physicians who completed an online survey containing eight vignettes of various OCD categories, 85% of physicians misidentified vignettes of individuals with OCD who had homosexual obsessions. This group of primary care physicians misdiagnosed OCD at an average rate of 50%. With the OCD vignettes about common OCD themes such as aggression/harm and pedophilia, only 1 in 5 physicians were able to provide an accurate diagnosis. Similar to the studies discussed above, physicians were much more likely to accurately diagnose OCD when symptoms pertained to symmetry and organization, which accounts for a small percentage of people with OCD. Additionally, in the cases of misdiagnosis, physicians were most likely to diagnose OCD symptoms as schizophrenia, obsessive–compulsive personality disorder, sexual identify confusion, or as having no

diagnosis at all—especially with regards to a vignette featuring obsessions about engaging in pedophilia (Glazier et al., 2014).

These rates of misdiagnosis have significant impacts on the treatment recommendations and medications that are prescribed. Physicians with incorrect diagnoses were more likely to prescribe antipsychotic medication and recommend psychodynamic therapies such as psychoanalysis (Glazier et al., 2014); neither treatment is considered first-line or evidenced-based (APA, 2007; Koran & Simpson, 2013). These treatments may be ineffective or, worse, expose individuals to potential harm and reduce their hope.

In looking at how U.S. psychiatrists treat OCD, Blanco et al. (2006) estimated that 39% of people with OCD receive appropriate pharmacotherapy and only 7.5% receive cognitive behavioral therapy. Additional research has examined the attitudes of psychiatrists toward people with OCD ($N = 91$), with the majority feeling pity, understanding, and empathy (Kusalaruk et al., 2015). However, approximately one-third felt that patients with OCD talk too much and waste a lot of time, and that clinicians needed more patience to work with OCD compared to other disorders. Eighty percent of this sample believed OCD was difficult to treat. Unsurprisingly, psychiatrists who expressed confidence in exposure therapy reported high levels of positive attitudes toward these clients (Kusalaruk et al., 2015). Just as the general public struggles to identify and characterize OCD, so too do doctors who struggle to overcome stereotypes and misinformation in order to accurately diagnose the disorder and connect patients with the treatment they need.

Mental Health Clinicians' Knowledge of OCD

It has been my experience that clients usually have seen several therapists prior to receiving a diagnosis of OCD and/or specialized treatment for OCD, in part because therapists lack education and understanding of the heterogeneity of OCD. In a study of therapists and psychologists ($N = 360$), about 77% misidentified a vignette about an individual who was obsessed with the fear that he might be gay (Glazier et al., 2013). The misidentification rates for other vignettes were lower but still concerning: 43% of the participants misidentified pedophilia obsessions, 32% misidentified aggressive obsessions, 29% misidentified religious/scrupulosity obsessions, and 16% misidentified contamination obsessions. Similar to primary care physicians, the clinicians who misdiagnosed the vignettes were more likely to diagnose or label the problem as sexual identity confusion, a specific phobia, impulse control disorder, or pedophilia. Even among clinicians who specialized in cognitive behavioral therapy (the treatment of choice for OCD), one-third misidentified the vignettes as presenting something other than OCD.

Glazier and McGinn (2015) studied the ability of doctoral students in APA-accredited counseling psychology, clinical psychology, and school psychology programs to identify OCD. Although it is notable that these students were far more likely to diagnose OCD when the vignette was about symmetry and contamination than taboo obsessions (consistent with the research discussed above with physicians, mental health clinicians, and the general public), it is particularly interesting that these students displayed a gap between their perceived knowledge of OCD and their actual knowledge. As part of the study, students completed a survey in which 82% stated they were somewhat or very knowledgeable about OCD. However, when they were asked about

specific OCD manifestations (e.g. harming, sexual thoughts, etc.) they reported being not at all aware or not very aware of these specific symptoms. Notably, when students were educated about OCD through a video, their ability to accurately diagnose and recognize this disorder improved.

Although it may be assumed that mental health clinicians are unbiased about mental health conditions due to their advanced training and understanding of mental health, their attitudes may often mirror that of the general public. In an online survey of mental health clinicians (many of whom specialize in CBT), stigmatizing attitudes were expressed toward many OCD symptoms, even contamination (Steinberg & Wetterneck, 2016). As previously mentioned, many clinicians also believe that people with OCD may be too fragile for treatment or that applying proper treatment (ERP) may cause harm (McKay, 2018).

In my experience, and as the above data suggest, there is often a discrepancy in knowledge—in both clinicians and in the general public—between individuals' perceived understanding of OCD and the actual nature of this disorder. This gap fosters an exaggerated sense of confidence in one's professional knowledge and leads to blind spots in diagnosis and treatment.

Skills of Effective OCD Specialists

Understanding the skills of those who specialize in treating OCD provides context for how this study is grounded in art therapy practice. First, understanding underscores the need for increased dialogue across disciplines to share these skills and knowledge about OCD, including how training and supervision may help address the lack of education in this area. Second, the study's focus highlights the importance of having

properly trained clinicians to treat the disorder and identifies current gaps in clinical practice, as well as the challenge that is experienced in rural areas and due to such barriers as race, class, and disability. Lastly, my thesis positions art therapists as uniquely situated to work as OCD specialists due to skills that may be beneficial for increased awareness and education about the disorder (e.g., the use of art making for public education) and knowledge of experiential approaches to therapy, discussed below. At the same time. it is important for art therapists to be able to navigate between various communities and foster mutualism—creating relationships that are reliant upon each other and mutually beneficial. An important byproduct of mutualism is improving access to care for clients and potentially reducing stigma through increased education across professions.

Skills of OCD Specialists

The use of evidenced-based treatment of OCD (e.g., ERP) requires specialized training and education about OCD and this treatment method. Franklin et al. (2013) distilled several areas of clinician competence that are required in order to become an expert in OCD treatment. These fall under the two categories of knowledge mastery and personal qualities of the clinician. Starting with knowledge mastery, a clinician must develop a depth of knowledge with CBT, which allows the therapist to communicate the course of treatment, anticipate challenges, and understand patient subtleties (Franklin et al., 2013, p. 746). Proper knowledge of assessment strategies also is emphasized within the knowledge mastery category. Assessment should include symptomology and severity of disorder, as well as a client's current level of functioning and impairment, past treatment history, strengths, supports, and eagerness or readiness to engage in therapy.

Assessment and correct diagnosis of OCD is a critical skill for clinicians, especially when assessing sexual or aggressive thoughts. Misdiagnosis of these symptoms can lead to improper treatment and possible harm to the client (Veale et al., 2009), such as involuntary hospitalization due to a clinician's fears that the client may act on their unwanted thoughts or a prescription of medication that is at best ineffective and at worst harmful. These actions also may reduce a client's hope and reinforce faulty beliefs that they are a bad person deserving of their suffering.

In addition to knowledge, there are many personal qualities in therapists that enhance OCD treatment. A therapist must be adept at fostering empathy, forming an alliance with the client, and reducing the sense of isolation that clients with OCD frequently experience (Franklin et al., 2013). The therapist's own tolerance of discomfort and ability to maintain presence and reflect care when a client is in distress are essential personal qualities that also must be developed in order to successfully assist clients in facing their own discomfort through exposure therapy (Bram & Björgvinsson, 2004). I would specify that the therapist's ability to sit with a client in discomfort without comforting or reassuring them is the critical skill, because the act of reassuring the client accommodates their OCD. That is, if a clinician is unable to sit with a client in discomfort, they are actually reinforcing the OCD by providing reassurance or comfort. Clinicians also must be able to examine their own biases and become adept at tolerating strong emotional responses in order to effectively work with this population.

In addition, given that people with OCD often experience intrusive, unwanted thoughts that may be considered taboo, clinicians need to be self-reflexively aware of their own stigmatizing attitudes, beliefs, or behaviors toward clients, especially when

clients are presenting with violent and/or sexual thoughts (Steinberg & Wetterneck, 2016). In other words, a therapist must develop a high level of comfort with taboo thoughts and hold the belief that all thoughts are acceptable and permissible.

An additional consideration with regards to taboo thoughts is that clinicians also need to be adept at risk assessment and avoid inflicting harm on clients through undue mandated reporting, prescribing inappropriate treatment or medication, hospitalization, or excessive caution about their symptoms (Veale et al., 2009). As an example, a client may disclose intrusive thoughts about pedophilia. A clinician may interpret such a disclosure as falling under mandated reporting obligations. However, for the client with OCD, these thoughts are repugnant and unwanted and are typically accompanied with crippling doubt about whether or not they may act on these thoughts. The client expresses fear about acting on these thoughts, not desire, and the dominant feelings about these thoughts are anxiety and guilt. Thus, reporting is unnecessary and doing so may give the client further "evidence" that they are a danger to others instead of normalizing intrusive thoughts and treating their OCD.

However, in more severe cases of OCD there can be significant risk that a person's compulsions will cause them or others harm. In the example described above, a client with pedophilia-themed OCD might avoid caring for their own children due to their fears, which often damages the relationship between child and parent. Additionally, depression is often a comorbid condition with OCD. Therefore, assessment for suicidal ideation should be approached with care to distinguish ego-dystonic OCD thoughts about self-harm from actual desires (Veale et al., 2009) Deficits in knowledge and clinical skills in any of these areas can often be offset through expert supervision and training (Franklin

et al., 2013; Steinberg & Wetterneck, 2016), and it is recommended that clinicians consult with an OCD specialist if they are uncertain about symptoms or risk assessment (Veale et al., 2009).

Skills of Art Therapists

Art therapists have many skills that are unique to the profession—for example, depth of knowledge and skill with art media and creative processes in addition to applied knowledge for specific physical and mental health issues. Art therapy also has been described as an interdisciplinary profession because art therapy training draws on aspects from the fields of art, psychology, counseling, and neuroscience, among others (Bucciarelli, 2016; Timm-Bottos, 2016). Due to this multifaceted training, art therapists may already be well equipped to integrate multiple counseling theories and additional training from other disciplines.

Art therapists are also uniquely trained to approach clients and treatment with an artist's lens and worldview to help conceptualize clients and treatment (Kapitan, 2018). That is, the worldview or lens of art therapists informs how they see a phenomenon, relate and connect to others, interpret information, and engage in a reflective process to validate understandings (Kapitan, 2018). As an example, within OCD treatment an art therapist may understand the phenomenon of OCD and interpret information based on the art media a client chooses, how they interact with this media, and the process in which they approach art. Clients with OCD may demonstrate behaviors such as perfectionism and reluctance to take risks within their art making, choosing materials and processes that feel familiar with a high degree of certainty. This is analogous to the condition of OCD in which one may be preoccupied with being perfect and fearful of making any mistakes or

taking any risks. In addition, there is often reluctance to engage in art processes that are emotive or bodily oriented, as they typically favor cognitively oriented experiences. Again, this can be a way of understanding OCD in that clients are utilizing and overly reliant on cognitive functions (e.g., obsessions and mental rituals) with the purpose of avoiding physical and emotional discomfort. Thus, clients may have little experience feeling their emotions or feeling embodied or may be fearful of these experiences if they have learned they can "cope" with distress by engaging in rituals. Clients often approach art making the way they approach their life; thus, the process of engaging with materials and art processes can provide an art therapist with a window into a client's experience with OCD.

Given that the primary treatment for OCD is an experiential therapy known as ERP or exposure therapy (in contrast to traditional talk therapy), art therapists may be well suited to employ this therapy as we have expertise in active, experiential approaches to therapy. Moon (2008) used the term "metaverbal" to describe the work of art therapists, noting that it is not accurate to say that our work is nonverbal; rather, our work extends beyond words (p. 56). As he noted, the core of art therapists' work lies within our interactions between our clients, artwork and art media, and our therapeutic process; that is, the meaningful experiences within therapy that defy words. I believe this is analogous to OCD treatment in that the process of actively facing one's fears through exposure therapy and sitting with a client through distress can defy words. Such experiential learning is often experienced and felt on a deep level, one that often is not suitable for words. Furthermore, the use of words can detract from the purpose of directly experiencing bodily sensations and emotions that arise as a result of exposure therapy.

Addressing the ever-evolving concept of an art therapist's professional identity, Kapitan (2014) offered five helpful skills that are also applicable for a therapist and client embarking on OCD treatment:

(a) curiosity, which means openness to the disrupting experience and an attitude that is willing to explore new learning opportunities; (b) persistence through the exertion of effort despite sure knowledge that there may be setbacks and disappointments; (c) flexibility, which means adapting to changing attitudes and circumstances; (d) optimism, in which one views new opportunities as potential for possible and attainable goals; and (e) risk taking, which means taking action in the face of uncertain outcomes. (p. 17)

In working with clients with OCD, all of these skills are applicable; however, the process of persisting through setbacks while modeling and encouraging risk taking is particularly useful with this population as the counseling process is not linear and exposure therapy is often conceptualized as a process of increasing one's tolerance to risk and uncertainty. As an example, a client is repeatedly invited to take risks when they engage in ERP in that they are invited to go toward their fear instead of away from it, sitting with the possibility that something bad may happen if they do so. Likewise, in art making, clients are invited to take risks by using unfamiliar materials, expressing emotions that evoke discomfort, and depicting scenarios related to their obsessions.

Lusebrink (2010) named three distinctions between art therapy and verbal therapy: the use of art media for expression and communication, the numerous meanings that are contained within an art product, and the therapeutic effects of the creative process (p. 168). It is my belief that these art therapy principles can be integrated into treatment

for OCD in several ways. First, art making can easily be incorporated into a client's exposure work to visually depict unwanted obsessions and come face-to-face with their fears. Collie et al. (2006) described this process in an article presenting best practices in art therapy for treating combat veterans, which included art-based exposure therapy to help reduce the fear associated with traumatic events. For clients with OCD, art-based exposure can be used in a similar way to depict upsetting, intrusive thoughts that evoke fear. For example, some people with OCD may find that specific colors can be used to reduce fear-based avoidance or challenge superstitious thinking related to these colors. With another client who experiences intrusive harm-based thoughts, a collage could be made using images that evoke these obsessions. The process of making the collage and subsequent practice of looking at the collage would be considered examples of art-based exposure therapy.

Secondly, the process of art making can be used to externalize inner thoughts, feelings, and experiences that are difficult to communicate verbally. These expressions are often useful when trying to communicate one's experience to family members and verbal communication is insufficient to truly capture the experience. Ehresman (2014) observed this phenomenon in her work with people with Alzheimer's disease, noting that art making can communicate experiences and increase connections with others when there are deficits in verbal communication. Although people with OCD may not have deficits in verbal communication, the distress often associated with OCD can be difficult to capture with words alone.

Lastly, OCD is a condition that promotes excessive thinking and cognitive functioning, often with avoidance of (and at the expense of) feeling emotions and/or

physical sensations. Hinz (2006) described a similar experience in treating clients with eating disorders, describing obsessions about food and weight as a cognitive defense mechanism to avoid experiencing feelings or embodiment. In my clinical experience, clients with OCD avoid uncomfortable feelings by using compulsions as a way to avoid or manage feelings, thus lacking skills of experiencing emotions and/or being in their bodies. Intentional and thoughtful use of art media and art processes may help clients to reduce their overthinking while promoting emotional expression and embodiment.

Although I have not found any art therapy literature about OCD, there are studies that show the effectiveness of art therapy in the treatment of conditions that are adjacent to OCD. For example, in a systematic review by Abbing et al. (2018) of randomized controlled trials on the use of art therapy for anxiety, art therapy was reported to have demonstrated effectiveness in promoting relaxation and improving emotion regulation. Similarly, Ramirez's (2016) literature review of art therapy for military veterans with PTSD reported that art therapy is effective in reducing anxiety, avoidance, and intrusive thoughts, all symptoms that are notable in OCD as well.

There is significant overlap between the skills of an OCD specialist and the skills of an art therapist. Synthesizing the literature above, I have developed a diagram (see Figure 1) that details several areas of skill overlap and suggests that training of both types of providers should emphasize these skills. The diagram also highlights the unique skills of both OCD specialists and art therapists and opportunities for each to learn from each other to reduce blind spots in treatment.

It is my belief that art therapists may be particularly suited to work as OCD specialists given their extensive training in experiential approaches to therapy. However,

as noted in the diagram and in the literature above, it is not enough to simply understand and utilize experiential approaches such as ERP; therapists also must be willing to sit with clients in discomfort, have deep knowledge of CBT and OCD, and be aware of their own biases toward taboo thoughts. Knowledge sharing between art therapists and OCD specialists may be one way to increase clinicians' understanding and awareness of treating OCD. Below, I will discuss additional methods to increase public education.

Figure 1

Comparison of Skill Sets of OCD Specialists and Art Therapists

OCD Specialist

Knowledge of CBT

Assessment strategies for OCD

Ability to make reliable predictions and understand the nature of OCD

Ability to keep the complex simple

Tolerance for discomfort and ability to sit with discomfort without fixing

Ability to foster alliance and empathy, reduce isolation

Use of metaphor and narratives

Persistence; "the best way out is through"

Understanding of implications of research on treatment

Use of experiential therapies

Art Therapist

Knowledge of art media & processes

Knowledge of art therapy assessment strategies

Knowledge of wide variety of counseling theories

Use of art concepts to conceptualize therapy (performance art, field-event theory, response art, etc.)

Methods for Increasing Public Education

It is evident that there is a need for increased public education about OCD. As discussed above, one method of increasing education about OCD is through information

and skills sharing among clinicians. Training and supervision are important elements to increase accurate diagnosis and improve access to treatment. Beyond this, there are several approaches to improving mental health literacy that are discussed below.

Public Health Campaigns

As Koh and Shrimpton (2014) identified, among public education strategies there are two ways to combat the problem of stigmatization of mental health conditions. One strategy is to increase mental health literacy, namely by disputing ignorance, myths, and fears. The other is to counter negative stereotypes by promoting positive images of those with mental health conditions. Art-based approaches to advocacy can utilize both of these strategies simultaneously.

Across the world there have been several examples of public health campaigns developed by the federal governments, the largest of these within the United States being anti-smoking and HIV/AIDS awareness campaigns (Fairchild et al., 2018). Despite their effectiveness, these campaigns are controversial due to their use of fear-based tactics to induce change in public behavior (Fairchild et al., 2018). One such example, in New York City, used posters with the slogan "It's Never Just HIV" that were targeted to young men of color and included graphic images of infections like anal cancer. In another, an Australian public health campaign about HIV/AIDS used imagery of the grim reaper as a symbol of death. This emphasis on fear has been particularly problematic for people living with HIV/AIDS because it can exacerbate existing stigma. Although fear-based campaigns that provoke strong emotional responses can be effective in some respects, they also can contribute to shame and embarrassment in those with the targeted conditions, which reduces their help-seeking behaviors (Fairchild et al., 2018).

Additional examples of public health campaigns can be found in the nonprofit sector. The National Alliance on Mental Illness has been shown to successfully educate the public about mental health conditions and to reduce stigmatization through legal means (e.g., improving protections for housing and in the workplace, etc.; Rüsch et al., 2005). Corrigan and Al-Khouja (2018) argued that the reduction of stigma should be a public health priority in part because stigma toward mental health conditions contributes to discrimination in the workplace, in housing, and in health care.

Additionally, the National Alliance on Mental Illness has demonstrated effectiveness in reducing stereotypes and stigmatization about mental health conditions by compiling narratives from people with mental health conditions in their video series *In Our Own Voice.* In Corrigan et al.'s (2010) study of college students and Brennan and McGrew's (2013) mixed-methods study of members of the general population who viewed these videos, participants reported reduction in stigmatizing attitudes of mental health conditions and appreciation of hearing directly from those who live with such conditions. As will be discussed in the following chapter, I also designed my study to share information directly from people with OCD with the general public, utilizing mixed methods to gather qualitative and quantitative data.

Internationally, studies in Germany (Dietrich et al., 2010) and Australia (Jorm et al., 2005) determined that public health campaigns aimed at improving public education and help-seeking behavior for people with depression have had some success. In both studies, regions of the country were targeted with a campaign to increase public knowledge about depression and compared to regions of the country that did not receive the information. In both studies, there was a notable change in previously held beliefs

about depression (e.g., people with depression lack self-discipline) and improved beliefs about treatment among those who lived in areas that had received the public information campaign.

Current Approaches to Increasing Mental Health Literacy Regarding OCD

The primary organization for public education about OCD is the International OCD Foundation (IOCDF). The purpose of this nonprofit is to promote awareness and education about OCD and to provide resources for clinicians and consumers (IOCDF, n.d.). The organization has intentionally taken a direct-to-consumer approach to educating the public about OCD. Szymanski (2012) described several direct-to-consumer strategies that IOCDF has employed in pursuit of their mission. These include an annual conference that provides content for researchers, clinicians, and people with OCD and their family members; a website with resources and information; and a newsletter that can be accessed by members of IOCDF. Additionally, the organization has engaged in media campaigns to increase available stories about OCD, developed a speaker's bureau, launched an OCD Awareness Week, and developed an outreach program titled "OCD in the Classroom." IOCDF also has spearheaded efforts to improve access to trained providers by providing training institutes and a database of treatment providers. Szymanski argued that direct-to-consumer methods, particularly websites and personal stories, are effective methods of increasing public awareness, reducing shame, and improving access to care.

Art as Advocacy

In a variety of settings, public viewing of artwork made by people with mental health conditions has been shown to increase empathy and understanding of mental

health conditions. Potash and Ho (2011) explored the responses of the public (including family members of people with mental health conditions and mental health clinicians) who viewed art made by people with mental health conditions. Their findings indicated that viewing this artwork increased the public's understanding of mental health conditions and promoted commonalities between artists and viewers. Potash and Ho wrote that exhibiting the artwork put a "human face" on mental illness and provided a glimpse into experiences that are often hidden from view (2011, p. 80). As I have noted, for many people with OCD their condition is hidden from view due to the tormenting thoughts and rituals that occur mentally and cannot be observed externally. According to Potash and Ho, the exhibited artwork allowed viewers to put aside preconceived ideas they had about mental health conditions and to see and accept the artists through their art. People with OCD need to be seen for their true experience, as they are often viewed through a distorted filter of stereotypes and misconceptions.

Koh and Shrimpton (2014) conducted a large-scale study about the role of art in increasing mental health literacy in Australia. This study utilized 10,000 responses from participants who viewed an art exhibition made by people who had experienced mental health conditions and/or psychological trauma. The exhibition also provided contextual information about the artists through written biographies and information about the artwork. Viewers completed a survey featuring a Likert scale and brief written comments were added by one-third of the participants. The survey results demonstrated that over 90% of respondents agreed or strongly agreed that viewing the artwork helped them gain a better understanding of the nature of mental health conditions, increased their sympathy, and helped them appreciate the ability and creativity of people with mental

health conditions. The authors conceded that an assessment of knowledge and attitudes toward mental health conditions prior to viewing the artwork would have provided a measure of effectiveness and a longitudinal study of the study's effects also would help measure the study's efficacy.

Similarly, Yamauchi et al. (2011) assessed the public's attitudes of mental health conditions through public viewing of artwork. At a gallery viewing in Japan, wherein 277 participants viewed artwork made by people with mental health conditions, the participants overwhelmingly expressed positive and empathetic attitudes toward the artists in questionnaires they completed after the viewing. In diverse settings, including a state psychiatric hospital (Griffith & Bauer-Leffler; 2018) and a community mental health center (Thompson, 2009), there are similar results. In the case of Griffith and Bauer-Leffler's (2018) study, the artwork created by patients with mental health conditions was used to inform their treatment, as the artwork opened a dialogue between patients and staff about recovery.

Within the art therapy literature, the concept of using art making to invoke empathy has been studied in contexts beyond public viewing of art. Fish (2012) and Moon (2008) both have encouraged the use of the art therapist's artwork in response to clients to foster empathy for clients with whom they work. Franklin (2010) explored therapist–client art making as an empathic, art-based intervention to increase intersubjectivity—that is, the attuned, relational space between therapist and client. A historical example of the use of public viewing of art to promote empathy can be traced to the 1940s, when art educator Friedl Dicker-Brandeis worked with children in the Terezin concentration camp north of Prague. Although not formally an art therapist,

Dicker-Brandeis's framework for art education holds many similarities to the modern-day

practice of art therapy (Wix, 2009). Dicker-Brandeis used her art classes with children as

a way to honor her students' experiences and foster empowerment in the face of

atrocities, as a pedagogy, and as an aesthetic, which Wix (2009) termed "aesthetic

empathy" (p. 152). Dicker-Brandeis promoted the idea that art can be a method to portray

one's direct experiences and that these images can be an intermediary between the artist

and the public. Specifically, she was interested in the idea that art promotes empathy. Art

can be used as a teaching tool to alter the public's view of another's experience and

promote public education (Spaniol & Bluebird, 2002).

A repeated theme within the art therapy discourse about art as a tool for advocacy

is the notion that public displays of art by marginalized populations can help right

societal wrongs. The reasoning is that because people with mental health conditions are

subjected to stigmatization, lack of full participation in society, and marginalization,

public sharing of artwork can expose these injustices and promote social change. In

support of this thesis, Thompson (2009) described a "gallery model" of art therapy that

displayed art made by people with mental health conditions in a public gallery within a

psychiatric hospital as a way to challenge power dynamics by promoting the artists not as

an "other" but as someone who represents health (p. 165). As he described, the public

display of artwork challenged viewers' expectations and stereotypes of people with

mental health conditions and instead fostered empathy, respect, and humanity.

Additionally, Potash and Ho (2011) described viewers' desires to "correct injustices" due

to the increased empathy and understanding that was experienced after viewing the

artwork made by those with mental health conditions (p. 79). Although not addressed in

these studies, artworks by marginalized populations could be shared with policy makers or used to facilitate collaboration between the artists and the broader community. Thus, taking a personal experience and making it public could effect change on multiple levels; by alerting the viewer to existing injustices, perceptions may shift on individual levels and through broader community engagement such as voting, lobbying, or other forms of activism.

Conclusion

OCD is a complex mental health condition and those who live with it face several challenges. Although there are evidence-based treatment modalities, people with OCD often experience long wait times between symptom onset and receiving effective care—if they ever receive treatment at all. This is a multifaceted problem that is contributed to by issues such as shame, lack of trained providers, racial discrimination, therapists' bias against evidenced-based treatments, and lack of mental health literacy among the general public and health care clinicians.

I theorize that the use of imagery, writing, and stories from people with OCD may help to elucidate the lived experience of people with OCD. It is my belief that people with OCD are the most equipped to share knowledge about this condition. Sharing this information with the public may help to raise awareness and improve understanding of this disorder, thus bridging the knowledge gap between the experience of those with OCD and clinicians who are in a position to assist them.

In the following chapter I will describe the methods used to carry out my research study. I will discuss the rationale for the use of mixed-methods approaches and describe participant recruitment, data analysis methods, validity, ethical issues, and limitations.

CHAPTER 3: RESEARCH DESIGN AND ETHICAL CONCERNS

It is evident that there is a need for increased public education about OCD given the numerous barriers to treatment and the lack of mental health literacy about OCD, as discussed in the previous chapter. As described, people with OCD often experience hardships in receiving an accurate diagnosis and finding appropriate treatment. A further challenge is the lack of OCD research within the art therapy literature, making it necessary to first assess art therapy and related clinicians' knowledge of the disorder to begin to address my research problem and use the results as a foundation for future research. Therefore, the purpose of my study was twofold: (a) to elucidate the lived experience of obsessive–compulsive disorder and (b) to both assess students' and clinicians' knowledge of OCD as determined by the effects of a brief video on OCD.

Research Design

To address the problem and its purpose, I conducted a mixed-methods phased study with two components. Mixed-methods research is defined as the use of both qualitative and quantitative research methods in a single study (Chaumba, 2013). Mixed-methods research provides for an in-depth understanding of participants' lived experience while also allowing researchers to develop precise measures based on contextual, real-life information (Hanson et al., 2005). Additionally, because mixed-methods research draws from more than one research paradigm, it may honor both analytic and subjective knowledge and is useful when trying to "convey the needs of individuals or groups of individuals who are marginalized or underrepresented" (Hanson et al., 2005, p. 226). As I have discussed, people with OCD are frequently misrepresented through stereotyping and images of OCD that are accurate to their lived experience are underrepresented.

The research study followed an exploratory sequential design (see Figure 2 as a template for this process). In accordance with Creswell and Plano Clark (2018), the method begins in the first phase with data collection and analysis of qualitative data to understand a phenomenon, in this case OCD. In the second phase, the analyzed qualitative data are used to build a quantitative instrument such as a pre/post test. This instrument includes qualitative elements to provide richer data. The quantitative/qualitative instrument is then administered to a new set of participants, in this case practitioners and graduate students. Lastly, the analyzed data are interpreted "in what ways and to what extent the quantitative results generalize or extend the initial qualitative findings" (p. 87).

The first phase of my study utilized qualitative procedures by which people with OCD participated in workshops where they made art, created writing samples, and engaged in semi-structured interviews to elucidate their lived experience of OCD. I analyzed and condensed these data for the second phase, which consisted of a nationwide survey with physicians, graduate art therapy and counseling students, and licensed mental health clinicians. These groups participated in pre/post testing and qualitative questioning to determine any changes in their knowledge and understanding of OCD before and after viewing the data.

Figure 2

Diagram of Exploratory Sequential Mixed-Methods Design

Qualitative Data Collection & Analysis	
Workshops with people with OCD to identify key themes of lived experience	Coding and thematic analysis to analyze data

Qualitative Results Used to Develop Instrument	
Short film made to illustrate workshop themes	Pre/post test developed with Likert scale and open ended survey questions

Quantitative & Qualitative Data Collection & Analysis	
Nationwide survey to assess clinician and student knowledge of OCD before and after film	Statistical analysis and thematic analysis

Phase 1 of the Study

Participants and Setting

For the first phase of this mixed methods study, inclusion criteria were that participants were 18 years old or older, able to travel for an in-person workshop in Portland, Oregon, and have a diagnosis of OCD. I vetted participants to confirm they met the requirements prior to participation. To recruit participants, I created a flyer that advertised the study and provided an overview of the purpose, requirements, and contact information. Recruitment methods included posting flyers in clinicians' waiting rooms, promoting the study through social media, and emailing the flyer through the local nonprofit organization OCD Oregon. This process yielded a sample of eight participants.

I provided the informed consent form via email prior to their participation in the workshops. The informed consent was created to ensure understanding of the purpose of the study, how their data would be used, measures to protect confidentiality, and potential risks and benefits of the study (see Appendix A). At the time of the workshop, all participants were given a hard copy of the consent form to review, which was also reviewed verbally and signed prior to beginning the workshop procedures. Participants were reminded within the informed consent form and verbally during the study that their participation was voluntary, and they could opt to withdraw from any portion of the study at any time without repercussions. This phase of the study was reviewed and approved by Mount Mary University's Institutional Review Board.

Data Collection Procedures

Data collection for the first phase of the study consisted of three workshops with the participants ($N = 8$). Each workshop was held at my private practice and followed an identical format. The workshop was repeated three times to allow participants to choose the date and time that was most convenient for them. To begin, participants were welcomed into the space and given a verbal description of the research study and outline of the process in which they would partake. They were told they could leave at any time or opt out of any portion of the workshop without consequences. Each participant then reviewed a paper copy of the informed consent (Appendix A), were given the opportunity to ask questions, and signed the forms. In total, each workshop took approximately 90 to 120 minutes to complete. Participants were allowed approximately 45 minutes for art making and written responses to reflection on their work followed by 45–60 minutes for

semi-structured interviews. Five to 10 minutes were allotted at the beginning and end for opening and closing of the workshop.

To facilitate art making, a wide variety of materials were arranged on a table including collage materials, watercolors, chalk pastels, markers, gel crayons, and a variety of paper. Participants were given three prompts to guide them in their art making and, additionally, could choose instead to ignore these prompts and make anything about their OCD. The three prompts were: "What do I want others to know about OCD?," "My OCD is like a ____," and "My OCD feels like ____." Participants worked individually but in proximity to others for about 30 to 40 minutes, after which they transitioned to the writing portion of the workshop while keeping their artwork in front of them.

The writing portion of the workshop was open-ended, and participants were verbally given options to create a written response or description of their artwork, poetry, a short story, or anything they wanted to communicate about the experience of having OCD. Seven participants completed their writing during the workshop and one participant brought in writing previously completed that they felt was appropriate for the purpose of the study.

For the semi-structured group interview, participants sat in a circle with their artwork and writing samples. Participants were reminded that they could opt out and decline participation at any time and were also notified when I started to audio record the interview. I asked the participants questions (below) and engaged them in a group discussion on these topics. Initially, participants engaged in a "round robin" style interview process in which each participant responded, taking turns until the entire group had the opportunity to share. However, as the process continued the process transformed

into a conversational style interview in which participants shared more freely with each other, often building off of what another participant had said. Each workshop discussion was audio recorded and transcribed.

Interview questions:

1. Can you describe your artwork?

2. What does your artwork communicate about your OCD?

3. How would you define OCD? Could you share the nature of your obsessions and compulsions?

4. When did you first notice symptoms of OCD? Was there a gap between symptom presentation and beginning therapy? If so, how long was this gap?

5. What do you want the public to know about OCD?

6. Are there misunderstandings about OCD? If so, what are they?

7. From what we've discussed and viewed today, what would you like to share with the public? Is there anything that would help others understand your experience?

In each workshop, every participant contributed to the semi-structured interview. Participants left their artwork and writing reflections with me; both were photographed and coded to eliminate the use of participant names. I informed participants that I would follow up with them by email by providing results of the workshops, encouraging feedback on the workshop results and subsequent film, and to provide any other updates on the research study. Participants were given a copy of their signed informed consent form and told they could contact me at any time with any questions about the research study. All hard copies of artwork, writing reflections, and informed consents were stored

in a locked cabinet in my private practice office as a safeguard. Digital copies of these items were stored on a password protected MacBook.

Data Analysis Procedures

Data from the workshops were analyzed by following Braun and Clark's (2006) method of thematic analysis, which is commonly used in psychological research to identify themes within data. Thematic analysis is a form of pattern recognition within qualitative data in which themes are identified to support or clarify the research purpose and the data are used to describe a phenomenon and/or interpret meaning (Roberts et al., 2019) Although thematic analysis shares similarities with phenomenological analysis, it does not require the researcher to suspend judgment and nor is it rooted in the philosophical basis of phenomenology (Kapitan, 2018). Rather, thematic analysis can be used to report "experiences, meanings, and the reality of participants" or can take a constructionist approach and examine the ways in which events, meanings, and experiences affect a "range of discourses operating within society" (Braun & Clarke, 2006, p. 9).

The essence of thematic analysis is identifying themes within data sets. Braun and Clarke (2006) defined a theme as "something important about the data in relation to the research question" that "represents some level of *patterned* response or meaning within the data set" (p. 10). Prevalence is only one factor in determining a theme. Additionally, themes cannot be measured purely by quantitative means alone. In some cases, each theme individually will not be the most prevalent within the data set, but together the themes capture important elements about a lived experience (Braun & Clarke, 2006).

For the purposes of this research, it was important to provide a rich, thematic description of the participants' experience of OCD in order to give the public receiving the information an accurate perception of their experience. In such a situation, Braun and Clarke (2006) recommended that researchers examine the entire data set, in this case art, writing, and interviews, as opposed to examining only a subset of the data. Although the method may contribute to a loss of complexity of the topic, it is a particularly useful method "when investigating an under-researched area, or with participants whose views on the topic are not known" (Braun & Clarke, 2006, p. 11). In the case of this research study, there was a dearth of art therapy research on OCD and the public's view of OCD was not known.

According to Braun and Clarke (2006), thematic analysis involves six steps. Figure 3, below, provides an overview of the entire process. The first step is to familiarize oneself with the data. For my purposes, this meant repeated and immersive readings of the written texts and transcripts, repeated listening to the audio recordings of the workshops, and laying out all of the artwork for immersive viewing. Additionally, I transcribed the audio recordings.

Figure 3

Overview of Thematic Analysis Process

Step 1	•Immersed self in data •Developed transcript of group interviews
Step 2	•Generated initial codes •Began organizing data into groups
Step 3	•Grouped codes into broader themes
Step 4	•Refined codes to develop broader themes •Discarded themes that did not have enough support
Step 5	•Further refined codes •Identified description of each code
Step 6	•Completed full written report of the codes •Shared this data with workshop participants for feedback

The second step involves the generation of initial codes. This step was completed manually, as opposed to using software; I began by organizing the data into meaningful groups through repeated reading and listening of transcripts and reviewing the writing and artwork. Within this step all potential codes and patterns were identified, as it was not yet known what was significant. For this process, I highlighted excerpts from the writing samples and transcription. In step three, codes were grouped under broader themes in order to develop overarching codes. This required physically grouping and placing the highlighted portions into envelopes, one for each overarching code. In step four, I refined the codes. It was evident after reviewing the content of the envelopes that some codes did not have enough data to support them, whereas others could be further combined into an overarching code. Step five involved taking the remaining codes and further refining and naming them, as well as dividing them into two broad themes. To do

so, I labeled each envelope with the essence of the code and developed a table to identify a description of each broad theme and its underlying codes. Finally, in step six, I produced a final written report of the resulting themes, which were used subsequently to develop the brief film and the survey instrument. First, however, the themes were shared with workshop participants to elicit feedback on their accuracy. With the use of iMovie to create the short film, I combined verbal excerpts from the interviews, all participant artwork, and written excerpts from written reflections—all of which were selected as reflecting the prominent codes that emerged from the thematic analysis process. The verbal clips were altered to protect participant confidentiality. Finally, participants were given the opportunity to review the film prior to its use, phase two of the study, in the nationwide survey. The review of the film allowed them to comment on the accuracy of the content and if they felt their voices were appropriately altered. Participants could also ask to have audio clips, writing samples, and/or artwork removed from the film.

Phase 2 of the Study

Participants

For the second phase of the project, I recruited participants using convenience sampling of three disciplinary groups of providers: physicians, mental health clinicians, and art therapy graduate students. However, due to low recruitment and participation rates from physicians this group was ultimately removed from the data. Remaining participants were recruited across the United States, although specific demographic data were not collected which, in hindsight, would have provided additional information as to the diversity of the sample. The criteria for participation required participants to be a mental health clinician with a minimum of a master's degree or a graduate art therapy or

counseling student within the United States. Using my personal and professional networks, I sent an initial invitation letter by email, wherein participants were asked to participate in an online survey. My professional networks also shared this email with their own networks. In addition, I posted the survey link and study information on online forums such as those hosted by the Southern California Art Therapy Association and the American Art Therapy Association. I also distributed the link through social media such as Facebook and LinkedIn.

Instrumentation and Data Collection Procedures

Within an exploratory sequential mixed methods design, the results from the first phase of the research study are used to develop an instrument for the second phase. In my study, I utilized codes from the first phase to develop a short film and to craft survey questions. To create the film, I reviewed all relevant codes and sought excerpts from raw data (e.g. excerpts from written reflections and interviews) that supported these codes. Every piece of artwork was displayed in the film with various writing samples and altered audio clips used as voiceover to provide a cohesive narrative of the key themes. As an example, one prominent code that emerged from the workshops was the lack of public awareness of covert symptoms of OCD such as taboo thoughts. Several audio clips and written excerpts were included to convey the importance of this experience. In addition, questions were then included in the survey to assess knowledge of these OCD symptoms after watching the film.

Participants in this phase of the study took part in a pre/post test survey to assess and self-report their knowledge of OCD before and after viewing a short film (see Appendix B). Prior to sharing the survey publicly, I tested it with peers and advisors to

assess the overall flow of the questions and to ensure accuracy; that is, that the survey questions accurately address the objectives of the research study. Participants who responded to the email invitation used a link to access the survey on a password protected survey platform (SurveyMonkey). Participants electronically signed a consent form before participating in the survey. Participants did not provide any personal information in order to ensure anonymity. All data were stored on a password protected MacBook. The survey took approximately 20–30 minutes to complete. This phase of the study was also reviewed and approved by Mount Mary University's Institutional Review Board.

The pretest portion of the survey asked participants to rate their knowledge of various dimensions of OCD on a 5-point Likert scales and answer open-ended qualitative questions. Participants self-reported the role that best defined them from a list of options and then answered questions related to their formal training and knowledge of OCD. Finally, they were asked to describe a typical client with OCD, identify symptoms of OCD, name five words to describe OCD, and describe what clients with OCD need from clinicians.

After completing the pretest portion (Items 1–8), participants were asked to click on an embedded link in the survey that directed them to the film created from the workshop participants' artwork and verbatim audio clips. After participants watched the film, they affirmed that they had done so (Item 10) and then completed the survey by continuing with the posttest portion (Items 10–17). Participants were again asked to describe OCD, identify 5 words to describe OCD, and state what they believed clients with OCD need from clinicians. Participants were also asked to rate their awareness of key OCD symptoms and assess the efficacy of the video in terms of whether or not they

agreed that it might improve a clinician's knowledge and understanding and whether it could serve to improve accurate diagnosis of OCD.

Data Analysis Procedures

In the second phase of the study, the data collected were both qualitative and quantitative, necessitating multiple methods of data analysis. For the open-ended survey questions, I used thematic analysis to identify key themes. All written answers were collected and assessed for prevalence and importance in order to distill key themes. The pretest and posttest themes were then compared to ascertain any changes in practitioners' thinking and awareness about OCD.

Additionally, for items that participants had rated on a Likert scale, a quantitative analysis was used by means of the Survey Monkey platform's software that quantified answers by percentages and bracketed the data based on role identification (e.g., graduate art therapy and counseling students' responses vs. clinicians' responses). As descriptive statistics, the analysis served two functions: to summarize the data collected and to describe the results (Wetcher-Hendricks, 2011). Descriptive statistics often are used as an initial step in order to determine if the data demonstrate the ability to be generalized to a broader population. Although inferential statistics were not performed, due to the abundance of qualitative data I was able to make some inferences from the results, which are described in Chapter 5.

<div align="center">

Ethics and Validity

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Ethics of Working With Vulnerable Populations

The study design presented unique challenges with regards to research ethics and the rights of human subjects. On the one hand, given the vulnerability of the study

population, consideration needed to be taken to protect Phase 1 participants by ensuring that sensitive information remained confidential and that the potential benefits of the study outweighed the risks they elected to take. Nevertheless, because this study placed advocacy and stigma reduction at its center, some participants told me that they felt it was important to be "seen" and "heard"; they no longer wanted OCD to be a secret, shameful condition, a stance that potentially could have jeopardized their privacy. However, these decisions about privacy and other ethical concerns rested primarily with me as the primary researcher, before any participant involvement.

To mitigate these risks, the research study design received IRB approval only after specific steps were taken. First, a detailed informed consent form provided an outline of the research study, how participants' data would be used, and how their confidentiality would be maintained (see Appendix A). The informed consent form also allowed participants to opt out of any portion of the study or the entirety of the study without penalty. To protect confidentiality no direct identifiers were used and artwork and writing samples were coded to avoid disclosure of a participant's name. Hard copies of artwork and writing samples were kept in a locked cabinet and digital images, transcripts, and other files were contained on a password-protected iPhone and MacBook.

Phase 2 of the study also required a separate IRB review and approval and a separate informed consent form (see Appendix B). However, because this portion did not involve vulnerable populations and did not gather any sensitive information from participants, the risks were minimal.

Ethics of Public Dissemination of Findings

As an end result of this study, some data, including artwork, voice-altered audio clips, and/or writing samples, will be disseminated publicly. Dissemination forums may include professional conferences, trainings, and through a public-facing multimedia website. Stallings (2019), who experienced similar challenges in developing a public-facing website for the advocacy of a vulnerable population from her research, noted that the risks and benefits of public disclosure must be assessed because there are few straightforward guidelines on public sharing of such research. In the case of OCD, my rationale, which was to increase access to and for stakeholders (e.g., individuals with OCD, clinicians, family members, etc.) through a public-facing website, was grounded on the lack of accurate representation of OCD and the need for increased information about OCD and its treatment. Prior to collecting data and as part of the informed consent, all participants were informed of the possibility of public disclosure and given the opportunity to opt out within the informed consent process. Participation in the study was not contingent on public disclosure and it was made clear that no direct identifiers would be used in any public forums.

Validity

Mixed-methods research design has the potential to strengthen a study's validity in that certain design elements may compensate for the limitations and weaknesses of any one research paradigm (Kapitan, 2018). In order to enhance this validity, mixed-methods design should not be used haphazardly; rather, the research design must fit the logic of the research problem and be used in such a way that the method enhances the study (Kapitan, 2018). As has been described in this chapter, I selected data analysis methods

that corresponded with each type of data collected and found that mixed-methods

approaches were required to address questions from two paradigms: quantitative and

qualitative.

Because this study follows an exploratory sequential design, there are specific

validity threats to this type of design that need to be addressed (Creswell & Plano Clark,

2018). One such threat occurs when the quantitative instrument is not developed based on

the qualitative results. In the following chapter, I will explicate the qualitative results and

discuss how these were used to develop the film and the survey. As Creswell and Plano

Clark (2018) described, an additional validity threat occurs when the same participants

are used for both the qualitative and quantitative portions of the study. In this study,

different samples were used and an effort was made to achieve a large sample size for the

quantitative survey, thus enhancing validity.

Survey research inherently includes its own validity risks. To minimize these

risks, Kapitan (2018) advised that a survey should be structured in such a way that it

addresses a clearly defined research objective. I have considered that my survey may

have confirmed what I already suspected; thus, my study might include confirmation

bias. However, I believe I designed the survey in such a way that this bias would be

limited. Through consultation with advisors and colleagues who reviewed the survey

prior to dissemination I believe I had designed a survey that could accurately measure

practitioners' knowledge of OCD before and after an intervention. In testing the survey, I

clarified questions for ease of comprehension and ordered the questions appropriately so

as not to prime or influence participants' answers. As an example, in the pretest portion I

did not ask participants about their awareness of specific symptoms (e.g., intrusive sexual

thoughts) so as not to bias their responses prior to watching the video. Additionally, to address the validity of survey research the population was clearly defined (graduate counseling and art therapy students and practicing mental health clinicians). I made an effort to obtain as many responses as possible in order to reduce bias (Kapitan, 2018).

Within the qualitative research paradigm, it is assumed that realities are socially constructed and thus research participants determine their own realities (Creswell & Miller, 2000). Because the first portion of my study was designed within a qualitative framework, validity is defined by how accurately the results obtained represent participants' realities and is credible to them (Creswell & Miller, 2000). To enhance validity in this regard, several steps were taken, including member checking and efforts to triangulate the data with multiple sources. When participants are asked to check the accuracy of the results put forth by the researcher, participants themselves validate researcher interpretations and thereby confirm their credibility (Creswell & Miller, 2000). During the process of thematic analysis, themes were triangulated by locating them across multiple data types (artwork, writing, and interviews), thus providing additional validation of the theme.

Member checking occurred at multiple points in the study. Research participants from Phase 1 were involved in several steps of the process. First, I shared the themes derived from the workshops with the participants and asked them to provide feedback as to whether the themes accurately described their experience of OCD. Secondly, the participants were invited to view the movie and provide feedback prior to the film's inclusion in the pre/post test. Additionally, mentors and academic advisors were included

in the process through consultations via a secure blog where my research process and raw data was documented.

Summary

Because this study explored both the lived experience of OCD and the need to assess clinicians' and students' knowledge of the condition, a mixed-methods study was warranted to provide both qualitative and quantitative data sets. Each set of data was analyzed using appropriate methods that followed the logic of the design (i.e., thematic analysis was used for qualitative data and statistical analysis was used for quantitative data). Validity was addressed at multiple points throughout, including the use of triangulation and using different participant for the two phases of the study. In the following chapter I will provide a detailed analysis of the data and display the results of the study.

CHAPTER 4: RESULTS

In this chapter I will provide the results from the mixed-methods study. I will begin with the results of the thematic analysis of data from the first phase of the study, which consist of the key themes from the workshops with people with OCD and their incorporation into both the film and survey instrument. Results from the second phase of the study include findings that were gleaned from the qualitative, open-ended survey questions and descriptive statistics that describe results from the rating questions.

Phase 1 Results

Workshops With People With OCD

The first phase of this research study addressed my initial research question: What is the lived experience of people with OCD? Eight participants engaged in the workshops, all of whom were over the age of 18 and self-identified as having OCD. Participants made artwork, engaged in writing exercises, and participated in group interviews about their experiences of OCD, with a particular focus on what they wanted the public to know about their disorder.

Results from the Thematic Analysis

Step 1

The purpose of this initial step was to familiarize myself with the data. First, I coded the data using a lettering system to avoid using any participant names and to keep the data anonymous. Then, over a period of several days, I engaged in sessions of viewing the artwork (see Appendix C for all artwork from the workshops), reading through writing samples, and listening to the audio recordings of the group interviews. I also produced written transcripts of each of the group interviews, which deepened my

familiarity with the data. I bracketed off my assumptions in an attempt to see the data as a whole. The semi-structured interviews produced a large amount of data and provided a comprehensive summary of the participants' experiences. The aim of these data was "to understand phenomena through meanings that people assign to them" (Roberts et al., 2019, p. 4). Thus, I oriented myself to the phenomenon of OCD and the possible meanings that were assigned by participants.

Step 2

To generate initial codes that emerged from the data I repeatedly listened to and read the transcripts, pulling out phrases that seemed meaningful and/or that were repeated several times. I also went through the written texts with the same process. I kept a Word document to create a list of quotes, key phrases, and potential codes and themes that had emerged.

One example of an initial code that began to emerge at this step was the pattern of believing oneself to be a bad person. Verbatim quotes from participants in their written texts and interviews verified the pattern, such as "OCD says 'you're a terrible person.'" An excerpt from a written text, shown in Figure 4, describes the belief of being a bad person. Figure 5 depicts this code with a participant's collage that includes a cut-out of the words "bad person."

Figure 4

Writing Sample Describing Belief of Being a Bad Person

> When I look at children or certain people or animals, I freak out because I think my thoughts are true and that by looking at them, I am harming them and that makes me a bad, gross person.

Figure 5

Artwork Depicting the Words "Bad Person"
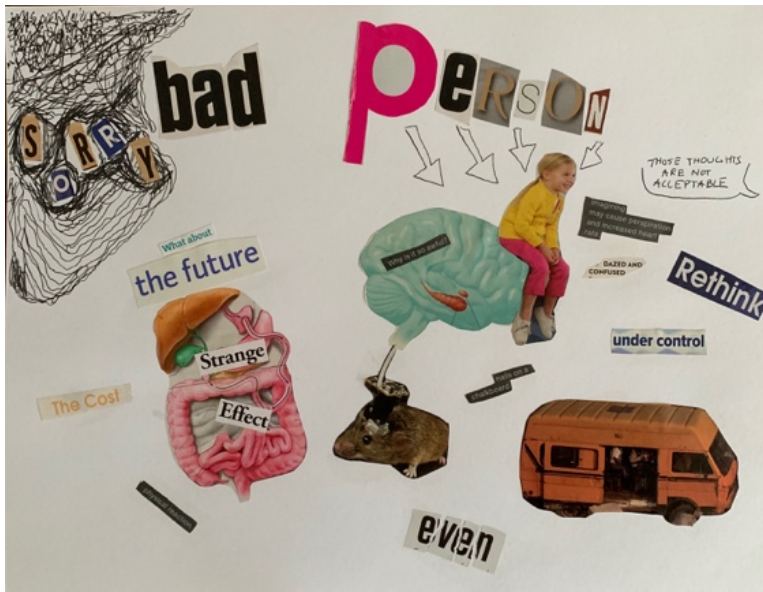
Step 3

Having collected a list of potential codes through repeated listening, reading, and viewing, the third step involved grouping these codes together. Using the Microsoft Word document I had created to document the excerpts and quotes that were possibly meaningful, I printed out and cut each excerpt on the pages into strips and then began organizing them into piles. As an example, one emergent pattern that repeated across the

data set was the physical nature of OCD that is often not seen by or discussed with others. Some of the quotes mentioned symptoms such as muscle tension, headaches, stomachaches, and other ailments that accompany OCD. I placed several quotes and excerpts from the group interviews in this pile. Other quotes mentioned the lack of attention U.S. society generally gives to "invisible" illnesses and the participants' desire for OCD to be treated with as much concern and validity as a physical illness, making direct comparisons between physical illnesses and OCD. This code also can also be seen in the artwork. For example, in Figure 6, a participant included the words "heart monitor" to convey her racing heart and fears of having a heart attack, as well as an image of tampons to represent how hormonal shifts make her OCD worse.

Figure 6

Artwork Depicting Theme of Physicality of OCD
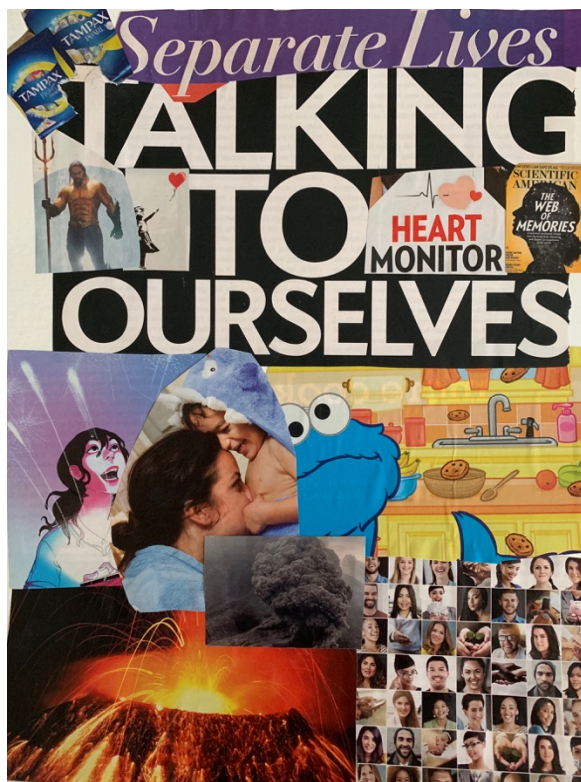
The third step process yielded 12 codes:

1. The physical nature of OCD (physical symptoms and comparison between OCD and physical illnesses)

2. Negative treatment experiences

3. Age at which participants first noticed OCD symptoms

4. Gap between symptom onset and diagnosis of OCD

5. Fear of judgment from others or worry about what others would think of them if they knew their thoughts

6. Invisibility (of symptoms, lack of awareness within society, etc.)

7. Stereotypes of OCD

8. Guilt as a predominant feeling that accompanies OCD

9. Belief in being a bad person

10. Existence of "bad" thoughts (harm, violence, pedophilia, etc.)

11. Hope or belief that treatment brings healing and help

12. Experience of OCD being a co-occurring disorder (with depression, body-focused repetitive behaviors, premenstrual syndrome/premenstrual dysphoric disorder, etc.)

Step 4

After placing all of the initial excerpts into the above thematic categories, there were remaining excerpts that did not seem to fit into any category. These were discarded, as there was not enough prevalence or strength to support them as main findings. For this step I also worked to consolidate the 12 codes into more concise categories, which produced a total of 9 codes.

Step 5

Next, I developed names and descriptions for each code. I reviewed the excerpts again to make sure they still fit accurately and precisely within the consolidated category. These codes were then further divided into two main themes that elaborated meaning with respect to the two purposes of the research study: (a) the participant's lived experience of OCD and (b) the participants' experiences with the health care system and what they wanted practitioners and students to know about OCD.

Step 6

In this final step of thematic analysis, I developed tables to display the resulting themes. Table 1 provides an overview of the first theme (i.e., the lived experience of OCD). The first column of the table presents the codes that support this theme: (a) bad thoughts/intrusive thoughts as a key feature of OCD, (b) belief that "I'm a bad person because of my horrible thoughts," (c) guilt as a predominant feeling in addition to anxiety/fear, (d) physical symptoms often accompany OCD, and (e) symptoms are often invisible to others.

As depicted in Table 1, several of these results correspond with symptoms described in the research literature, such as the occurrence of intrusive, unwanted thoughts that are often about taboo topics such as harming others or engaging in pedophilia. Despite these symptoms appearing as part of diagnostic criteria, participants felt it was important to highlight them and describe their specific thoughts to provide real-life examples. Participants noted that their intrusive thoughts greatly contrast with the symptoms more typically associated with OCD, such as handwashing and being overly neat. As one participant stated, she had been misdiagnosed for years "because I'm

a slob and my room was a mess," noting that therapists and family members did not

consider OCD as a diagnosis because these behaviors were contrary to the stereotype.

Participants expressed that there needs to be more public awareness of the true range and

content of OCD symptoms, especially for particularly disturbing symptoms that are the

most difficult for them to disclose to health care providers.

Table 1

Theme #1: OCD Lived Experience

Code	Description	Examples from the Data Set (Writing, Interviews and Artwork)
Bad thoughts/ intrusive thoughts as a key feature of OCD	Participants identified that intrusive thoughts (obsessions) are unwanted and/or repetitive thoughts that cause distress, sometimes experienced as images or urges. These thoughts go against the true desires of a person with OCD and are often taboo (e.g., violence/ harm, pedophilia, incest, etc.), and cause feeling responsible to make sure harm isn't done to others.	"I couldn't drive because I thought I might hit someone and be responsible for killing someone." Thoughts verbalized during the workshop included harming others, pedophilia/fears of being attracted to children, ruining others' lives, murdering, stabbing, genocide, images of having sex with family members, hurting animals, and suicidal thoughts. Figure 7 Figure 8 Figure 9
Belief that one is a bad person because of one's horrible thoughts	Due to the taboo nature of obsessions, participants noted that people with OCD often believe they are a bad person because they have these thoughts at all; their thoughts are evidence of badness.	"I worry I'm a bad person." "We feel like if we have a thought, we are that thought." "I'm a bad person. And I want to do anything I can to take that feeling away." "When I look at children or certain people or animals, I freak out because I think my thoughts are true and that by looking at them, I am harming them and that makes me a bad, gross person." Figure 5
Guilt as a predomi-nant feeling in addition to anxiety	OCD is often accompanied by anxiety, but guilt was also a predominant emotion. Guilt may be experienced because a person feels overly responsible to prevent harm.	"I never associated my OCD so much with anxiety as I did guilt." "Guilt is the fundamental feeling for me."

Physical symptoms that often accompany OCD	In addition to mental and behavioral symptoms, OCD is often experienced in physical symptoms. Participants affirmed that people with OCD also believe OCD is not given the same acknowledgment as a physical ailment.	"Visceral physical responses, heart races, tight stomach, shortness of breath." "Headaches, tension, weight loss." "I thought I had a heart attack. I went to the ER [emergency room]." "There's the phrase, 'Mental health is just as important as physical health,' and that's the truth. OCD can be fatal." Figure 6
Symptoms that are often invisible to others	Because obsessions and many compulsions are mental processes, they are not visible to others. In addition, as people with OCD, participants often attempted to hide symptoms from others due to fears of judgment or stigmatization.	"You may not be able to tell if someone has OCD. It's not always visible. It's not always cleaning and organizing." "OCD is like an iceberg. You're only seeing a small part on the surface." "I feel it important to mention that my compulsions were and are almost 100% invisible. They were things like avoiding, checking, flooding and praying."

Importantly, the result that describes the invisibility of symptoms also is found in the literature on OCD (discussed in the next chapter), particularly surrounding the symptoms of mental rituals and intrusive thoughts, both of which occur as mental processes that are all-consuming to the person with OCD but not visible to others. Participants voiced concern that the invisibility of their symptoms contributes to a minimizing of their suffering by others and the idea that OCD is a quirk that doesn't need to be taken as seriously as visible health conditions.

Figure 7

Artwork Depicting Obsessive Thoughts
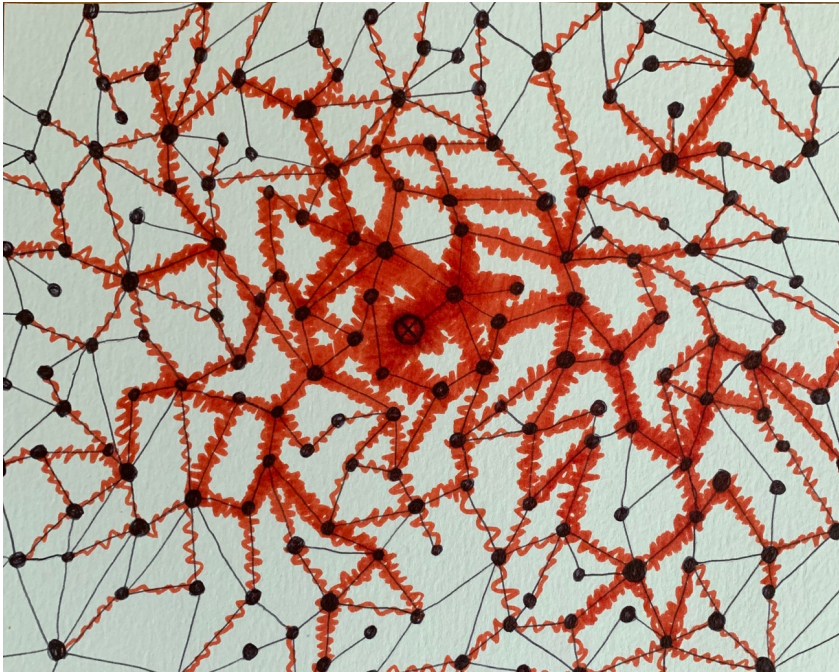
One example of the invisible symptoms of OCD are the taboo, unwanted thoughts

that occur for many people with OCD. As depicted in Figures 7, 8, and 9, the workshop

participants used their artmaking to depict what it is like to have these obsessions. In

reflecting on Figure 7, the participant wrote that it "represents[ed]my thought processes,

spiraling out from one fear to another, the uncertainty of my anxieties, loss of control,

helplessness. For Figure 8, the participant wrote "OCD is black and white thinking,

automatic thoughts and intrusive thoughts that produce anxiety."

Figure 8

Artwork and Description of Intrusive Thoughts
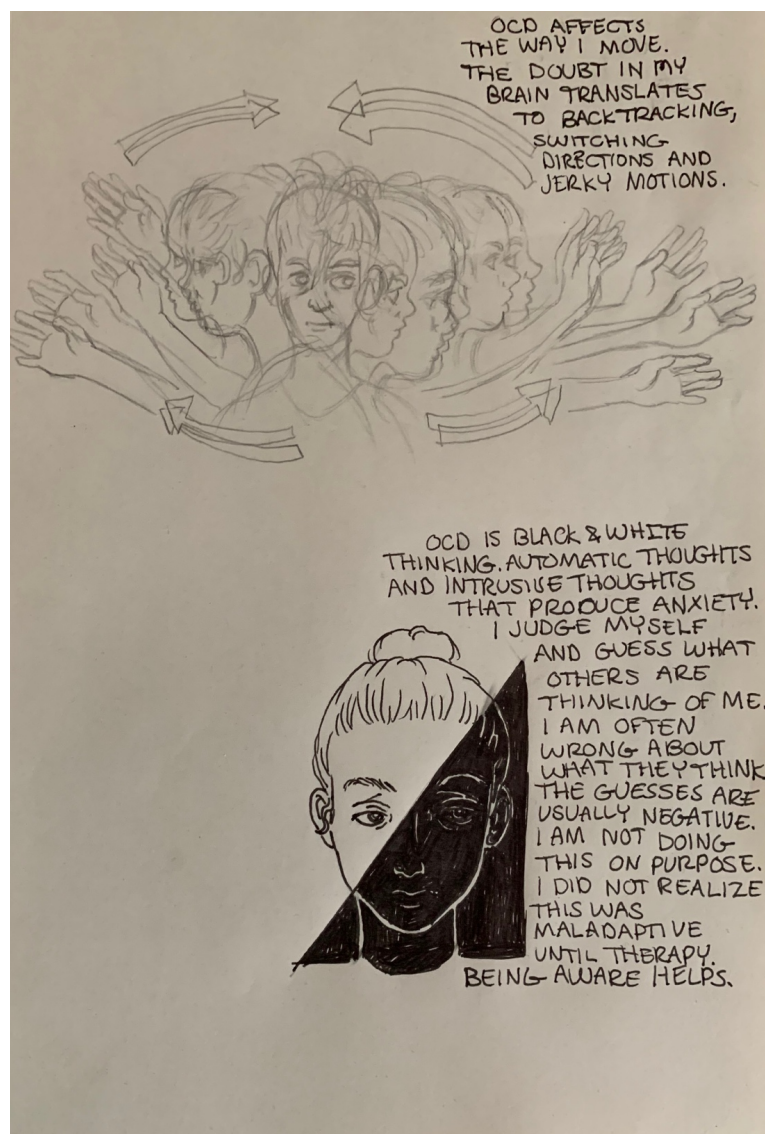
The participant who created Figure 9 described her artwork stating, "Basically

OCD feels like diving head first into an ocean of your worst nightmares, without a

lifeboat or even a life vest." For this participant, the choice of colors was meaningful as

representing the types of intrusive thoughts she experiences. She wrote, "I used different

colors in the whirlpool to represent my many different obsessions. The black sections are

the worst obsessions—the ones that bring the most pain. For me, that is POCD or

pedophile OCD."

Figure 9

Artwork Depicting Experience of OCD

Table 2 depicts the second overarching theme: experiences with the health care

system and what practitioners need to know about OCD. The four codes supporting this

theme are: (a) stereotypes of OCD are not accurate, (b) negative treatment experiences,

(c) often a gap between symptom onset and treatment, and (d) hope and treatment that

works. These results encompass what participants want health care practitioners to know.

During the workshops, participants shared experiences of when they first noticed OCD symptoms, which for all participants was during their childhood. Many of the participants described visits to several health care professionals before receiving a diagnosis of OCD. Some participants expressed the difficulty they had in sharing their symptoms with health care providers, in part due to their shame about their thoughts and in part due to fear about how a health care provider would respond to them, as well as prior negative reactions from health care providers. One participant described how she "recoiled" after having a negative interaction with a therapist when she disclosed her intrusive thoughts; following the incident she made a conscious choice to never share these thoughts again. Many participants said they wanted physicians and therapists to explicitly ask about intrusive thoughts so as to make it easier for people with OCD to disclose this information.

Table 2

Theme #2: Experiences With the Health Care System/What Practitioners Need to Know

Code	Description	Examples from the Data Set (Writing, Interviews and Artwork)
Stereotypes of OCD are not accurate	Participants stated that OCD extends well beyond stereotypical definition (cleaning, a quirk, being neat, something to aspire to, etc.) and often is minimized and not taken seriously by practitioners. OCD often involves horrific intrusive thoughts about taboo topics, which are often not visible to others. Stereotypes lead to misdiagnosis and other direct harm for those with OCD.	"I want others to know that OCD is REAL. It is not something that is about being 'anal' or neat and tidy. It is always lurking." "It is hurtful when people refer to OCD as a personality trait." "It took a long time for me to be diagnosed because I'm a slob and didn't fit the stereotype." "When we fixate on neatness stereotypes it prevents accurate diagnosis and OCD gets worse without intervention and appropriate treatment."

Negative treatment experiences	Participants emphasized that having OCD led to having negative experiences with the health care system when trying to access help for OCD. Therapists often minimize OCD, don't know what it is, misdiagnose, or express concern about intrusive thoughts that people with OCD have (the opposite of how clinicians should respond). Participants observed that many therapists state confidence in treating OCD but actually have little to no training.	"Last year, I asked my mom how the therapist didn't catch that I had OCD when intrusive thoughts are one of the trademarks. 'What did she tell me about my thoughts?' I asked. 'She told you that those thoughts weren't acceptable.' And I laughed, because I couldn't think of a worse thing to tell a person with OCD." "'Those thoughts are unacceptable.' No. 13 years between onset and diagnosis, that's what's unacceptable." "I want people learning about OCD to know: WE NEED EARLY DIAGNOSIS. I had 16 long years to build up a ferocious whirlpool of OCD." "People don't understand that it's a serious thing—like . . . serious." "My therapist said she specialized in OCD but had no idea what she was doing." "I saw a few therapists but they didn't know it was OCD." "A doctor was worried I might act on my POCD [pedophile OCD] thoughts." "Clinicians need to take on more responsibility to ask the right questions. Don't put that burden on the sufferer." "Clinicians and the public can react negatively when people share their intrusive thoughts." "Therapists who say they specialize in OCD but really don't are causing people with OCD harm and they're wasting people's time."
Often a gap between symptom onset and treatment	Participants stated that people with OCD often experience long wait times between first symptoms and diagnosis and/or treatment.	OCD started at age "5 or 6," "6 or 7," "9," "12," "a very young age, I was born worrying." "I can never remember a time that I wasn't worried." "Obsessions started at about 6 years old." "[I] had intrusive thoughts as a 6-year-old about hurting my sister." "First noticed OCD at age 8, first realized I could accidently harm somebody." Time between noticing symptoms and diagnosis and/or treatment: • 2 years to diagnosis, 11 years to effective therapy, 4 additional years to medication • 10 years to diagnosis, longer between diagnosis and effective therapy • 20+ years to diagnosis, 50 years until effective therapy, 20 some years until diagnosis

- 15 years to diagnosis, 20 years to treatment
- OCD symptoms since childhood, diagnosed years later
- "I was diagnosed with OCD 16 years after I started experiencing symptoms."

| Hope and/or treatment that works | ERP was the most frequently mentioned treatment by participants, although many also found medication, seeking community/support, and art making helpful. | "Through therapy I became aware of intrusive thoughts, maladaptive thinking, and the nature of OCD."

"ERP is the only thing that's helped."

"A specific expert in OCD is the only thing that's helped."

"OCD needs specialized treatment. General mental health counseling and support groups can be helpful but didn't do anything for my OCD."

"Community, being with others with OCD is important. To have my own experience reflected back and feel understood." |

Participants shared several barriers to treatment and expressed a desire for health care providers to become more educated about OCD in order to break down these barriers. Many of the participants shared that they experienced relief from OCD once they were connected with a treatment specialist. Participants described the stress they experience in trying to navigate the mental health landscape and find care, and that they found this process to be easier once they received a diagnosis or were given accurate information about exposure therapy.

Obsessive–Compulsive Disorder: What Every Clinician Should Know

To communicate the lived experience of OCD that the participants described in art and in words, and to convey what the participants wanted clinicians to know in order to improve treatment and increase public awareness, I incorporated the results of the workshops into a short film, which is now available online (Headley, 2019). I composed the film to depict the themes and illustrated them with audio recording excerpts from the group interviews, writing excerpts, and photos of all of the artwork created during the

workshops. Because I did not video record the workshops, there are no images of participants in the film. The film highlighted in particular those symptoms that are very difficult to share, such as intrusive unwanted thoughts and feeling like a bad person. However, it should be noted that due to time constraints (i.e., to ensure that the finished film could be easily viewed without fatigue or disinterest setting in), certain results were omitted, such as the physical nature of OCD. Figure 10 provides a still shot of the opening title of the film.

Figure 10

Opening Title of the Film

The film also informed viewers about the participants' experiences with the health care system and what they want practitioners to know. For example, in several audio clips participants discuss the shocking gap between symptom onset and accurate diagnosis. As one participant stated, "The therapist that my mom sent me to when I was six years old basically told me, 'those thoughts are unacceptable' and I just got a generalized anxiety diagnosis. So, it took 13 years from that point [to receive a diagnosis of OCD]". Another

stated symptoms appeared at age four or five and a diagnosis of OCD was given at age 23.

Participants also discussed the benefits of specialized therapy, primarily ERP. With the audio of participants in the background, each participant's artwork can be seen displayed on screen. Figure 11 depicts a still shot of the film as audio clips of participants are used as voiceover, stating, for example, "It [OCD] started at eight, and 16 years to get diagnosed, and exposure response prevention [ERP] and specific expert in OCD is the only thing that's ever worked." Others discussed the difficulty of finding a therapist when many therapists advertised expertise in this area without actual knowledge or training. One participant's message to therapists ill equipped to treat OCD was, "We're miserable, don't waste our time." Another stated therapists are doing more harm than good by advertising themselves as treating this condition without specialized training.

Figure 11

Still Shot of Artwork Used in Film

To provide some context for the artwork and audio clips, as well as to succinctly convey the participants' narrative, I also presented frames with written text (Figure 12 is one example). These frames were placed in the middle of the short film to educate viewers with the words from participants about the types of obsessions common among people with OCD, underscore with factual information about the wait times for those seeking treatment. At the end of the film, frames with written text are utilized to synthesize the information from the film and to provide more information about what people with OCD need from clinicians based on what participants had said in the workshops.

Figure 12

Still Shot of Frame with Written Text

People with OCD are not dangerous; they are fearful and often feel immense guilt for these unwanted thoughts they cannot control
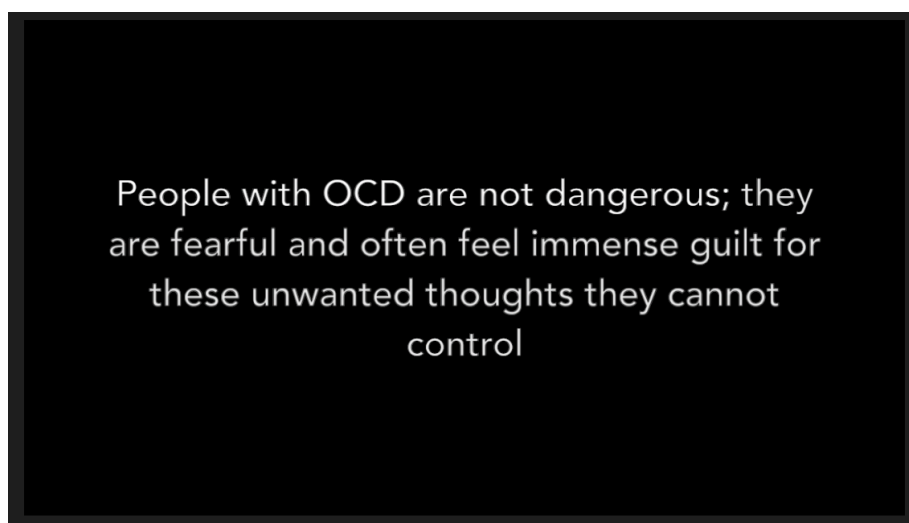
Validity of the Results From Phase 1

To check the validity of these results as accurately depicting what participants had shared, I sought to share Tables 1 and 2 with them and invited their response. Of the eight participants, four responded to my invitation to confirm the results. One participant who reviewed the results stated, "You captured what the essence of OCD is like." Another

stated, "I feel everything in the data analysis document was *extremely* accurate." None of the participants disagreed with the results.

The film also underwent a member checking process to determine whether the film accurately depicted the participants' message to viewers and to confirm that the audio recordings had been sufficiently masked to protect participants' identities. Three of the eight participants responded to my request to confirm accuracy of the film, all of whom provided feedback confirming that the movie accurately captured their experience and what they wanted others to know about OCD. However, because all of the participants did not participate in the member checking process it is possible that some members did not view the film or the data analysis tables or that they disagreed but did not make their opinions known. It is also possible that the participants who did offer feedback felt social pressure to affirm my work as the researcher or felt they couldn't disagree due to differences in power between us.

Once the results and the final film were validated, I incorporated them into the survey design for Phase 2, the results of which are presented below. In an exploratory sequential mixed-methods design it is essential that the data from Phase 1 inform the instrument developed to be used in Phase 2 (Creswell & Plano Clark, 2018). To that end, many of the questions in the survey were based on the results from the workshop. For example, for Item 13 ("Prior to viewing the film, how aware were you of the following…") survey participants were asked to assess, among other symptoms, their knowledge of how guilt and the belief that one is a bad person present as key features of OCD, both of which were codes that emerged during the workshops. To assess their

knowledge, survey participants also were asked to describe OCD before and after viewing the film.

Phase 2 Results

Nationwide Survey of Students and Practitioners

The purpose of the second phase of the study was twofold: (a) to assess current knowledge of OCD held by clinicians and students and (b) to test the hypothesis that knowledge and understanding of OCD would improve after watching a short film in which people with OCD share their experiences. To test this hypothesis, I developed and distributed a nationwide survey (see Appendix B) to assess clinicians' and students' knowledge before and after an intervention of viewing the study's brief film.

Participants

In total, there were 78 respondents to the survey. I had hoped to involve respondents in three categories: mental health clinicians, art therapy and counseling graduate students, and physicians. Table 3 depicts the breakdown of these groups. Due to a lack of response from physicians (only three participants in this category completed the survey: two specialists and one primary care physician) these results were omitted from data analysis. In addition, the respondents who selected "other" in response to the question about their professional role were omitted from the study, as their self-identified roles did not fit into one of the three categories. This left two main groups—graduate art therapy and counseling students and mental health clinicians—included in the study results ($N = 74$). There were 31 graduate students and 43 mental health clinicians.

Table 3

Survey Respondents by Role

Role	*n*	%
Psychologist	3	4.1
Mental health clinician—Credentialed and licensed art therapist	10	13.5
Mental health clinician—Licensed therapist	8	10.8
Mental health clinician—Credentialed art therapist	15	20.3
Mental health clinician—master's degree/unlicensed	7	9.5
Art therapy and/or counseling graduate student	31	41.9

Clinicians included a mix of art therapists, counselors, and psychologists, all of whom had earned a minimum of a master's degree. Of the 43 mental health professionals, 15 were credentialed art therapists, 8 were licensed professional counselors or marriage and family therapists, and 10 were credentialed art therapists who were also licensed as professional counselors or marriage and family therapists. No other demographic information was collected.

Quantitative Results of Pretest

Assessing Formal Training on OCD

The first portion of the survey was designed to assess what the survey respondents knew about OCD prior to watching the brief film. As can be seen in Table 4, survey respondents were asked to describe their formal training on OCD, from *none at all* to *a great deal*. Of the 43 clinicians, 70% stated they had little to no training on OCD. Similarly, 74% of students stated they had little to no training in OCD, suggesting that many clinicians may not receive any additional training on OCD after graduate school. Among clinicians, only three respondents reported receiving "a lot" or "a great deal" of

formal training on OCD, and only one student reported having "a lot" of formal training

on OCD.

Table 4

Survey Respondents' Formal Training on OCD

Role	None at all	A little	A moderate amount	A lot	A great deal
Psychologist	0 (0%)	1 (33.3%)	2 (66.7%)	0 (0%)	0 (0%)
Mental health clinician—Credentialed and licensed art therapist	4 (40.0%)	3 (30.0%)	1 (10.0%)	1 (10.0%)	1 (10.0%)
Mental health clinician—Licensed therapist	1 (12.5%)	4 (50.0%)	3 (37.5%)	0 (0%)	0 (0%)
Mental health clinician—Credentialed art therapist	5 (33.3%)	6 (40.0%)	3 (20.0%)	1 (6.7%)	0 (0%)
Mental health clinician—master's degree/unlicensed	4 (57.1%)	2 (28.6%)	1 (14.3%)	0 (0%)	0 (0%)
Total	14 (32.5%)	16 (37.2%)	10 (23.2%)	2 (4.7%)	1 (2.3%)
Art therapy or counseling graduate student	10 (32.3%)	13 (41.9%)	7 (22.6%)	1 (3.2%)	0 (0%)

All respondents who reported having "a little" or more formal training were asked

to describe the training they had received. Nearly all respondents reported general

graduate school studies, with several specifically mentioning psychopathology

coursework. This provides additional support for the hypothesis that most training on

OCD occurs in graduate school. A few clinician respondents mentioned post-graduate

continuing education courses or self-study that occurred after graduate school, but these

represented a minority of respondents.

Assessing Self-Reported Knowledge of OCD

Respondents were asked to self-assess and rate their knowledge of OCD using a Likert scale from *none at all* to *a great deal*. Table 5 depicts the results. Although the majority of both clinicians and students stated they had little to no formal training on OCD, a higher percentage of each group reported having a moderate amount of knowledge. Among clinicians, just under half (47%) reported having a moderate amount of knowledge. This finding suggests that despite little to no formal training, students and practitioners generally believe they have at least moderate knowledge of OCD. Still, only three students and clinicians reported having "a lot" or "a great deal" of knowledge about OCD, suggesting that deep knowledge and understanding of the disorder is limited.

Table 5

Survey Respondents' Self-Reported Knowledge of OCD

Role	None at all	A little	A moderate amount	A lot	A great deal
Psychologist	0 (0%)	1 (33.3%)	2 (66.7%)	0 (0%)	0 (0%)
Mental health clinician—Credentialed and licensed art therapist	2 (20.0%)	4 (40.0%)	2 (20.0%)	1 (10.0%)	1 (10.0%)
Mental health clinician—Licensed therapist	0 (0%)	3 (37.5%)	5 (62.5%)	0 (0%)	0 (0%)
Mental health clinician—Credentialed art therapist	0 (0%)	7 (46.7%)	8 (53.3%)	0 (0%)	0 (0%)
Mental health clinician—master's degree/unlicensed	0 (0%)	4 (57.1%)	3 (42.9%)	0 (0%)	0 (0%)
Total	2 (4.7%)	19 (44.2%)	20 (46.5%)	1 (2.3%)	1 (2.3%)
Art therapy or counseling graduate student	1 (3.2%)	16 (51.6%)	13 (41.9%)	1 (3.2%)	0 (0%)

Qualitative Results of Pretest

To gain a better assessment of clinicians' and students' knowledge, the pretest survey included several open-ended questions. Respondents were asked to describe a client or person known to them who has OCD, describe the symptoms of OCD, and list up to five words that describe OCD. Respondents also were asked what clients with OCD need from them as a clinician, to assess knowledge of treatment needs with this population. I analyzed the open-ended questions (aside from the one that asked respondents to list five words to describe OCD) using thematic analysis to distill core themes. I believed that including these questions would provide a more nuanced understanding of practitioner knowledge and fill in gaps and limitations from the quantitative data. The qualitative data provide understanding of participants' knowledge and allow better understanding as to whether their knowledge of OCD accurately aligns with the lived experience of OCD.

Five Words Associated With OCD

In looking at the words that both the clinicians and the students used to describe OCD the choices were strikingly similar and occurred at similar rates; therefore, these data were combined. As can be seen in Table 6, "anxiety" or "anxious" were words that were used most frequently. In addition, most responses included some variation on "obsessions," "compulsions," "obsessive compulsive," or some combination of these words.

Table 6

Words Provided by Survey Respondents to Describe OCD

Words used to describe OCD	n	%
Anxiety or anxious	32	43.2
Repetitive or repetition or repeating	28	37.8
Compulsion or ritual	25	33.8
Obsessions compulsions or obsessive compulsive	20	27
Control	17	22.9
Fear	7	9.5
Behavior	6	8.1
Obsession	5	6.8
Thoughts	5	6.8
Intrusive	5	6.8
Trauma	4	5.4

Describe a Typical Client With OCD

Respondents were asked to describe a typical client with OCD whom they've treated or knew. In distilling the data from both students and clinicians the following themes emerged:

- had not treated clients with OCD

- offered stereotypical descriptions of OCD

- described symptoms not consistent with OCD

- offered vague descriptions, knowledge unclear

For the first theme, that some respondents had not treated anyone or did not know anyone with OCD, this disclosure was understandably more common among students' responses,

although it also appeared in some clinicians' responses. These responses did not provide any further details on what the respondents think OCD may entail.

Another emergent theme were the descriptions of clients with OCD using stereotypical symptoms. Several respondents described clients who engaged in handwashing, checking (e.g., locks, stove, etc.), or ordering objects in a certain way. Some phrases respondents used included "making things even," "someone who has specific routines," "intense need to order things," and "counting things to feel OK." Within this theme many described behaviors that people feel compelled to do such as washing their hands multiple times. Many expressed an understanding that compulsions were done in an effort to reduce distress. Although these are accurate descriptions of a subset of people with OCD, the prevalence of this theme suggests a lack of broad understanding of how the disorder can manifest. A handful of respondents did identify intrusive thoughts, including images of violence and scrupulosity as symptoms related to their clients with OCD, but these were in the minority of responses.

Additionally, some respondents described symptoms unrelated to the diagnostic criteria of OCD, suggesting that these respondents were inaccurately identifying a client with OCD and describing instead clients with other mental health conditions. As examples, some respondents described eating disorder behaviors, health anxiety (hypochondriasis), or specific phobias; another respondent described symptoms that are consistent with obsessive–compulsive personality disorder (controlling, rigid, interpersonal conflict, etc.). Others simply mentioned how OCD co-occurs with other disorders such as autism, schizophrenia, and body-focused repetitive behaviors, but did not describe the OCD symptoms specifically.

Similar to the results for the question that asked respondents to identify up to five words they associate with OCD, some respondents also provided vague descriptions for a typical client with OCD, such as describing someone who has "obsessions" and has "compulsive habits." Others described clients as "rigid" and having "rituals." From these responses it is unclear how much knowledge of OCD the respondents have, as the terms they offered were vague and not defined within their answers.

Describe Symptoms of OCD

Further assessment of survey respondents' knowledge was ascertained by asking them to describe the symptoms that characterize OCD, based on their knowledge. For both clinicians and students, the answers could generally be distilled into two categories of responses: accurate descriptions of OCD symptoms and vague descriptions of symptoms. The majority of responses depicted an accurate understanding that someone with OCD may be plagued with intrusive thoughts and obsessions that lead to the feeling that one must do some sort of behavior to neutralize the thoughts or find relief from anxiety. For most respondents the connection between the obsessions and compulsions was well understood and a few mentioned the concept of mental compulsions as a part of this cycle. Some identified intrusive thoughts and the distressing, impactful nature of OCD. Some respondents mentioned the idiosyncrasy of the obsessions and compulsions that are unique to each individual. In general, clinicians provided more accurate descriptions of symptoms than students did.

As in other results discussed above, many respondents described symptoms in vague terms such as "obsessions" and "compulsions" while providing only minimal detail, making it difficult to ascertain their true understanding of these terms. Some

responses suggested an understanding that the behaviors and/or OCD process is repetitive, as indicated in phrases such as "repetitive behavior" or "repetitive rituals" or "repeated thoughts." Students were more likely to provide general responses, but also were more likely to state that they had not worked with clients with OCD, as noted in the previous section.

What Do Clients Need From You as a Clinician?

Lastly, respondents were asked what clients with OCD need from them as a clinician. This question was included to ascertain their understanding of treatment goals and the needs of clients with OCD. The data were distilled to four primary themes:

- compassion, understanding, and/or empathy

- psychoeducation

- coping skills or tools

- evidence-based treatments (ERP, CBT)

The most prevalent of these themes was the need to provide compassion and understanding for people with OCD. Many emphasized the need to be nonjudgmental and to provide acceptance of the client and their experiences. This theme highlights the desire for practitioners to help clients with OCD; whether or not specific treatment interventions are known or used, clinicians want to provide support and be helpful to their clients.

Many respondents highlighted the need for psychoeducation. Some mentioned the need to educate clients about OCD, including an understanding of their specific symptoms and the broader condition of OCD. Some suggested this knowledge may help increase clients' insight into their OCD and increase understanding of the impact of OCD on their lives. Some respondents also identified coping skills and tools that can be learned

in therapy. Some stated this more generally by maintaining that people with OCD need "coping strategies" or "skills to manage intrusive thoughts," whereas others provided specific examples of such skills as cognitive restructuring, relaxation training, and journaling.

Other respondents specifically mentioned the need for training in cognitive behavioral therapy, with a general understanding that this is considered an evidence-based treatment. Of the 74 respondents, one student and four clinicians specifically mentioned ERP, with two others describing the need for "desensitization," although it is unclear if this referred to exposure therapy or not. Although not significant enough to emerge as a theme, some respondents described techniques that are contraindicated in OCD such as providing reassurance, helping clients understand the deeper or underlying meanings of their thoughts, thought stopping, and identifying substitution behaviors to help clients replace compulsions with other behaviors.

Summary of Pretest Results

In summation, the pretest portion of the survey revealed an absence of formal training on OCD for the majority of respondents. Moreover, a high percentage of respondents who lacked formal training indicated that they felt they had moderate knowledge of OCD, suggesting higher confidence in their knowledge than what would be indicated based on their education. In general, respondents were able to provide broad descriptions of OCD, such as describing OCD as repetitive and involving obsessions and compulsions. Most respondents understood OCD to be a thought-based disorder with repeated or constant upsetting thoughts. However, the majority of responses did not indicate in-depth understanding of the disorder, as evidenced by the omission of specific

description of symptoms. Importantly, few survey respondents provided answers that were consistent with the lived experience of the participants with OCD in the study, such as the existence of taboo thoughts and experiences of guilt.

Quantitative Results After the Film Intervention

The posttest portion of the survey was designed to assess clinicians' and students' knowledge of OCD after watching the short film depicting artwork, writing, and narratives of the lived experience of OCD. As noted in the results from Phase 1, the workshop participants expressed a desire for practitioners to understand in particular the invisible symptoms of OCD such as shame, guilt, feeling overly responsible for others, and taboo intrusive thoughts. They also wanted clinicians to understand how difficult it was to receive an accurate diagnosis and treatment.

Assessing Survey Respondents' Knowledge of Specific OCD Symptoms

The posttest portion of the survey included some additional questions that were not in the pretest, which aimed to specifically assess respondents on their knowledge of the OCD symptoms that were shared in the video. Respondents were asked to rate how aware they were of these symptoms prior to watching the video. Table 7 depicts the results. The table highlights the symptoms and key features of OCD and provide insight into respondents' prior knowledge and awareness of these symptoms. Notably, 38% of respondents reported that they were not at all aware of sexual obsessions as a symptom of OCD, with 70% of total respondents stating they had little to no awareness of this symptom before watching the video. Conversely, the same number of respondents (70%) reported that they'd had "a lot" or "a great deal" of awareness of external OCD symptoms such as cleaning and arranging items. This result appears consistent with the

pretest data that showed that clinicians and students generally knew about overt and stereotypical symptoms of OCD, but few described or had knowledge of invisible symptoms such as taboo intrusive thoughts. These results suggest that overall, clinicians and students have a high degree of awareness of symptoms that can be observed, such as external compulsions like handwashing or organizing objects, but less awareness about covert symptoms.

Similarly, 66% of respondents reported having previously had little to no awareness about violent or harming obsessions as a common symptom of OCD and 58% of respondents stated they'd had little to no awareness about the experience of believing oneself to be a bad person as a common symptom of OCD.

Table 7

Respondents' Awareness of Key OCD Symptoms and Features Prior to Watching Video

OCD symptom or feature	Not at all	A little	A moderate amount	A lot	A great deal
Obsessional OCD (OCD symptoms that are thought based/not visible)	4 (5.5%)	17 (46.7%)	23 (31.5%)	20 (27.4%)	9 (12.3%)
Harming/violent/aggressive obsessions as a common symptom of OCD	21 (28.4%)	28 (37.5%)	9 (12.2%)	9 (12.2%)	7 (9.5%)
Sexual obsessions (e.g., pedophilia, incest, etc.) as a common symptom of OCD	28 (38.4%)	23 (31.5%)	10 (13.7.0%)	7 (9.5%)	5 (6.9%)
External or visible symptoms of OCD such as contamination/cleaning, symmetry/arranging items, etc.	0 (0%)	4 (5.4%)	18 (24.3%)	28 (37.9%)	24 (32.4%)
Mental rituals/compulsions as a symptom of OCD (i.e., rituals that cannot be observed externally)	4 (5.4%)	13 (17.6%)	18 (24.3%)	23 (31.1%)	16 (21.6%)

Guilt as a key feature of OCD	14 (18.9%)	22 (29.7%)	17 (23.9%)	14 (18.9%)	7 (9.5%)
Experience of being a bad person as a key feature of OCD	21 (28.4%)	22 (29.8%)	13 (17.6%)	14 (18.9%)	4 (5.4%)

These results demonstrate the need for increased education about OCD symptomology that may be invisible, such as intrusive thoughts and negative self-talk or beliefs about oneself.

To further assess respondents' knowledge of specific OCD symptoms, qualitative data were gathered from responses to the question, "What symptoms were you least aware of?" Nearly half of all responses (35 out of 74) mentioned a lack of awareness about sexual intrusive thoughts. Lack of awareness about harming or violent intrusive thoughts was mentioned 23 times. This result corresponds with the research discourse that obsessional OCD, which is primarily focused on intrusive thoughts of harm and taboo sexual content, is believed to be prevalent among people with OCD although it can be hard to track due to shame and difficulty disclosing these symptoms. Lack of awareness of guilt and shame was mentioned 18 times and a few respondents also mentioned not having known about the prevalence of misdiagnosis and long delays between symptom onset and diagnosis. Nearly all responses to this question focused on aspects of the disorder that are often invisible.

Impact of Video as Advocacy and Educational Tool

To assess the impact and effectiveness of the video as an advocacy and educational tool, respondents were asked to report whether the video had improved their knowledge and understanding of OCD (see Figure 13) and their ability to accurately diagnose OCD (see Figure 14).

As seen in Figure 13, 47% of respondents felt that watching the video had improved their knowledge and understanding of OCD "a lot" or "a great deal," with 36% reporting that the video helped them "a moderate amount." All respondents found the video at least somewhat helpful in improving their understanding. However, in terms of improved ability to diagnose OCD (see Figure 14), 42% of respondents reported that the video helped "a little" or "not at all" compared to only 19% that found it helped them "a lot" or "a great deal."

Figure 13

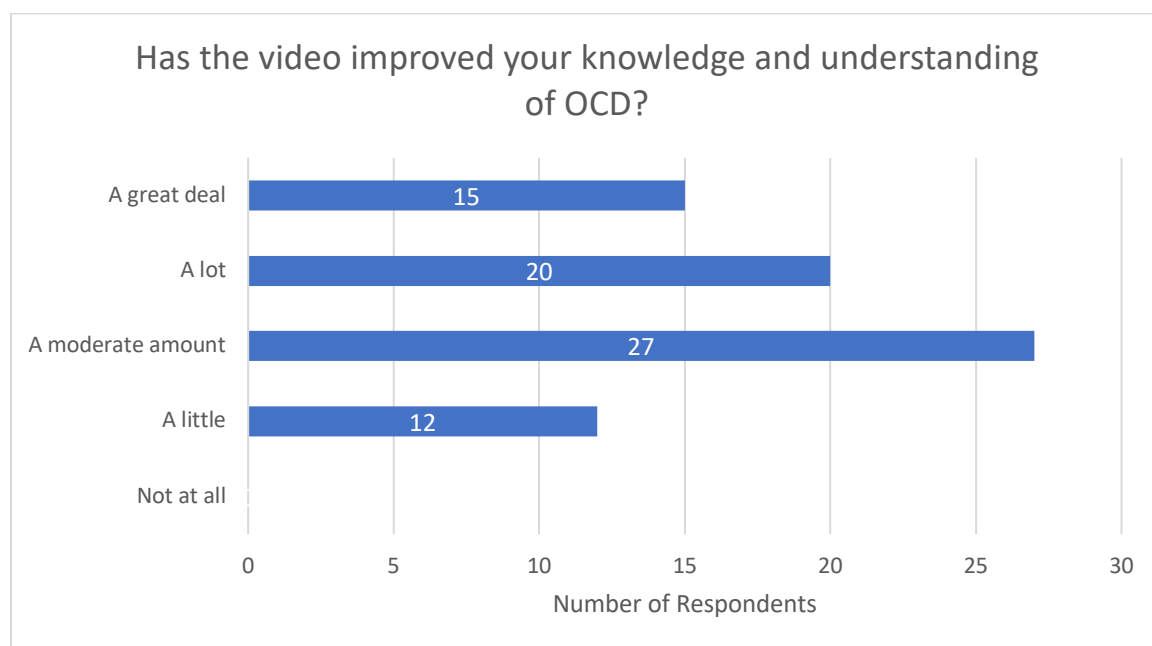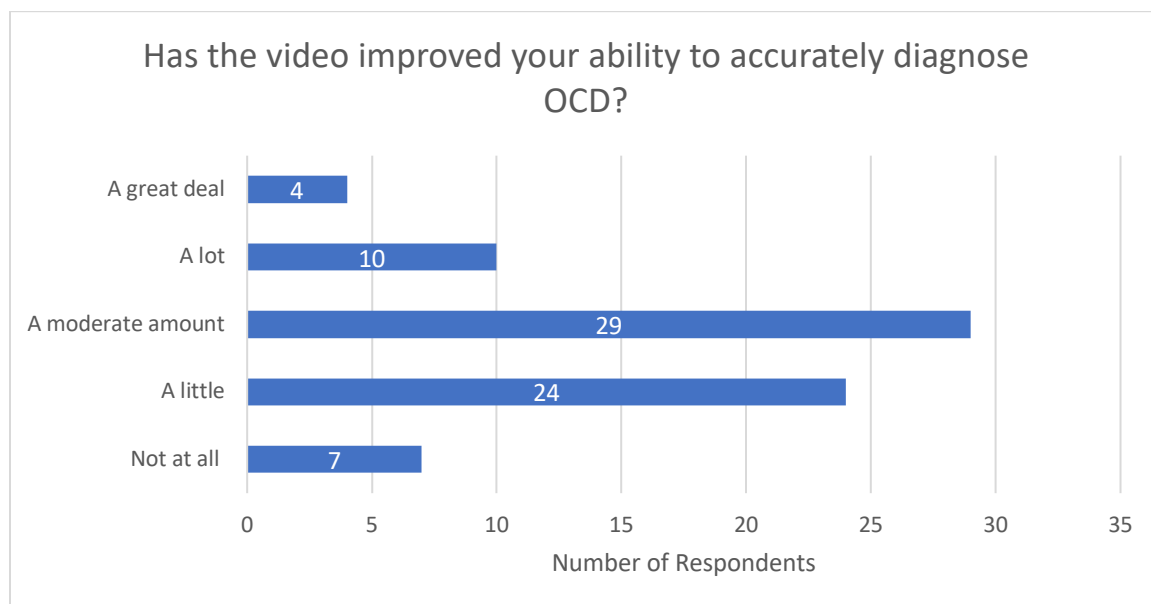*Impact of Video on Awareness and Understanding of OCD*

Figure 14

Impact of Video on Ability to Diagnose OCD

It is possible that hearing directly from people with OCD helped clinicians and students understand the lived experience of this condition and provided increased empathy but either did not improve their understanding of diagnosis and treatment or did not change their self-assessment of their knowledge and skill. Because it was centered on the themes that emerged from the workshop, the video did not include a focus on treatment and this may provide implications for further research studies.

Qualitative Results After Film Intervention

As in the pretest portion of the survey, open-ended survey questions were included to provide deeper understanding of practitioners' knowledge after viewing the film. Questions that were repeated in the posttest portion were (a) "What do clients with OCD need from you as a clinician?" and (b) "Write up to five words that you associate with OCD." Open-ended questions unique to the posttest portion of the survey were (a) "What symptoms were you least aware of?," (b) "How would you describe OCD to

another clinician?," and (c) "Describe any reactions, comments, or thoughts you had to the video."

Describe OCD to Another Clinician

The question that asked respondents how they would describe OCD to another clinician illuminated respondents' knowledge of OCD after watching the film. Nearly all respondents provided an accurate description of the cyclical nature of OCD in which intrusive, unwanted thoughts repeatedly enter the brain, creating a distressing reaction (anxiety, guilt, fear, shame, etc.). Compulsions are then done in an effort to reduce these feelings and/or in an attempt to stop or control these thoughts. Many respondents acknowledged the invisible symptoms of OCD such as intense guilt and the presence of "bad" thoughts. As one respondent wrote, "It's a disorder marked by intrusive thoughts, anxiety, and guilt. The symptoms are often invisible. Accurate diagnosis helps with better treatment for clients/patients."

Many of the responses to this question acknowledged the heterogeneity of OCD and described the need for clinicians to understand how OCD can have a varied presentation. In contrast to previous answers, which provided stereotypical understandings of OCD, many of these responses specifically described intrusive thoughts that were violent or sexual in nature and expressed an understanding that these thoughts go against the true nature of the person with OCD and are unwanted. One clinician described OCD in this way:

> A disorder with debilitating, intrusive thoughts that can be different for each
> person but could include harming others, guilt of being a bad person, sexual
> including pedophilia, and related to cleanliness or body functions. It is a serious

disorder that needs specialized treatment. It often goes undiagnosed and people

who suffer from it may not share what they are experiencing with others, even

clinicians.

As can be seen in this response, this clinician is acknowledging the variety of intrusive

thoughts that someone with OCD may have and expressing an understanding that OCD

symptoms may be hard to share, leading to underdiagnosis.

What Do Clients Need From You as a Clinician?

Respondents also were asked what people with OCD need from them as a

clinician. These responses were analyzed using thematic analysis and compared to the

answers obtained in the pretest portion of the survey. The key themes that emerged from

the responses to this question are:

- empathy, compassion, and understanding

- knowledge and competency

- ERP or referrals to an OCD specialist

Many respondents described the need to bear witness to a client's experience and

suffering without judgment. Some described the need to validate clients' suffering, noting

the importance of this in the face of stereotypes of OCD, which may minimize the

disorder. One respondent stated that clients need "understanding that it is serious

disorder, not a joke or an issue of cleanliness and has a real, negative impact on

individuals' life [*sic*]." Although this theme of compassion and empathy also appeared in

the pretest results, post intervention (i.e., viewing the film) the respondents were more

specific in their responses. Although some still described only general empathy, many

other respondents described the specific ways in which a clinician needs to be

understanding. As an example, some respondents described the need to be compassionate about a client's intrusive thoughts, with one stating the importance of acknowledging to the client "that they are not a bad person and they are not their thoughts." Another stated the need for clinicians "to understand that it is scary and causes shame and deep self-criticism."

Many respondents also noted the need to be knowledgeable about OCD and demonstrate competency in treating this disorder. Some described the need for general knowledge of the disorder; others discussed the need to understand the difference between thoughts and actions or understand that people with OCD will not act on these thoughts. Also notable was respondents' clarity regarding the need to clearly state their limitations in knowledge or competency in treating OCD and the importance of not overstating their ability to treat OCD. This finding is notable, given that many of the participants in the workshops expressed frustration and anger that in their experience clinicians had misrepresented or overstated their knowledge of OCD. As one participant expressed in the video, "Don't waste our time," in reference to clinicians who say that they treat OCD but actually have little to no training in the disorder. Many of the workshop participants had seen several therapists before finding a specialist in OCD and described the difficulty navigating the health care landscape to find a specialist. One finding gleaned from the pretest portion of the survey was that practitioners want to be helpful to their clients; as the workshop participants described, the best way to be helpful may be to accurately present to clients areas of expertise and limitations of one's scope of practice.

In contrast to pretest responses, numerous respondents reported the need for a clinician to provide ERP or refer individuals with OCD to a treatment specialist if they themselves are not appropriately trained. One respondent described the needs of clients with OCD in this way:

> They need me to work with them from a perspective that is nonjudgmental and encouraging AND knowledgeable about OCD as a specialized area of treatment. Either I can be trained in these methods or I can refer [them] to someone who is. It is scary that unprepared clinicians take on OCD clients without really knowing how to help them; treatment-as-usual isn't enough.

This response highlights the need to refer for specialized treatment and demonstrates understanding that general therapy is not effective for people with OCD. Although numerous respondents expressed that clients need ERP, it is not clear whether participating clinicians have appropriate training to provide this, but at least they were recognizing the need for this evidence-based treatment. Many responses described the need to refer clients to an OCD specialist, suggesting that these respondents did not feel confident in their own ability to treat OCD after watching the video.

Five Words Associated With OCD

As in the pretest portion of the survey, respondents were asked to write up to five words they associate with OCD after watching the film (see Table 8). Table 8 depicts the prevalence of the most common words respondents used to describe OCD after watching the film. In contrast to the pretest responses, wherein a larger number of respondents described OCD using words such as obsessive and/or compulsive, answers were more varied and nuanced in the posttest. The words "shame," "guilt," "secret," "hidden,"

"invisible," and "unwanted thoughts" or "unwanted" appeared in significant numbers in these responses and did not appear at all in the pretest responses. Table 9 depicts a comparison of the words used in the pre-test and the post-test.

Table 8

Words Provided by Survey Respondents to Describe OCD After Film Intervention

Words used to describe OCD after video	n	%
Anxiety	30	40.5
Guilt	25	33.8
Fear	22	29.7
Shame	19	25.7
Intrusive	15	20.3
Obsessions or obsessive	14	18.9
Compulsion or ritual	13	17.6
Control	10	13.5
Secret or hidden or invisible	8	10.8
Unwanted thoughts or unwanted	7	9.5
Obsessions compulsions	7	9.5
Worry	5	6.8
Repetitive	5	6.8

Table 9

Comparison of Words Used to Describe OCD Before and After the Film

Words used to describe OCD	Pre-test		Post-test	
	n	%	n	%
Anxiety or anxious	32	43.2	30	40.5
Repetitive or repetition or repeating	28	37.8	5	6.8
Compulsion or ritual	25	33.8	13	17.6

Obsessions compulsions or obsessive compulsive	20	27	7	9.5
Control	17	22.9	10	13.5
Fear	7	9.5	22	29.7
Behavior	6	8.1	0	0
Obsession	5	6.8	14	18.9
Thoughts	5	6.8	4	5.4
Intrusive	5	6.8	15	20.3
Trauma	4	5.4	1	1.3
Unwanted thoughts or unwanted	1	1.3	7	9.5
Guilt	0	0	25	33.8
Shame	0	0	19	25.7
Secret or hidden or invisible	0	0	8	10.8

In the pretest responses, "anxiety," "repetitive," and some variation of "obsessive compulsive" were the most used terms, suggesting that clinicians had only a vague understanding of OCD. In the posttest responses, "anxiety" was still the most used word, but in combination with other prevalent terms such as "guilt," "fear," "shame," and "intrusive," providing more context and specificity for the use of this term.

The words "fear" and "intrusive" appeared in both the pre- and posttest answers but occurred in higher numbers in the posttest. Although some respondents still used the words "obsessions," "obsessive," or "obsessions compulsions" to describe OCD, these appeared fewer times than in the pretest responses, suggesting that respondents had more accurate language to describe OCD after viewing the film than simply the words contained in the name of the diagnosis.

General Comments and Feedback on the Video

The final open-ended question provided respondents with the opportunity to provide feedback on the video and offer insight into the efficacy of the video as a tool for advocacy. Hearing stories directly from people with OCD along with viewing their artwork proved to be particularly poignant, as many respondents commented on how powerful it was to hear firsthand accounts of OCD. As one clinician wrote:

> I thought it was very important to hear from the clients in the video discussing their specific symptoms, as well as their negative experiences with therapy. I actually went to my *Psychology Today* page afterwards to make sure I did not have OCD listed as an area of focus!

Many participants in the workshop expressed a desire for clinicians to accurately represent their expertise in OCD and hoped that sharing their stories through this research project would advance this cause. Some respondents stated they were inspired to do more research on OCD because the video had sparked their curiosity and made them aware of their limited knowledge of the disorder. As one graduate student wrote, "Very appreciate [*sic*] of the approach. Hearing descriptions from clients was helpful. Seeing the imagery helped to underline the commentary. It made me want to learn more in order to provide the best possible care."

Some comments focused on respondents' limited training on OCD or belief they knew more about OCD than they did. One plainly stated, "I'm just not knowledgeable of the disorder. I need more education when it comes to the disorder." Another clinician wrote, "Seeing the artwork combined with the person's story was really powerful. It significantly improved my understanding over academic training. DSM criteria in no way

give this kind of personal, full picture." For many, the video highlighted blind spots in their knowledge and motivated a desire to learn more. As the comment above eludes to, graduate training is often insufficient when it comes to OCD. Implications for training, specifically the inclusion of client narratives and artwork in art therapy pedagogy, will be discussed more in Chapter 5.

Summary of Posttest Results

The results from this test demonstrate several outcomes. First, respondents generally found the video helpful in increasing their understanding of OCD, but less helpful as a tool for improving diagnostic skills. The majority of respondents also reported lack of awareness of key features of OCD such as taboo intrusive thoughts, belief of being a bad person, and the experience of guilt as a key emotional feature of OCD. These results were further confirmed in the qualitative data wherein respondents provided more nuanced and accurate descriptions of OCD presentation and greater understanding of what clients need from them as clinicians (e.g., ERP).

Summary

This chapter presented the results of an exploratory sequential mixed-methods study conducted to illuminate the lived experience of OCD and understand clinicians' and students' knowledge of OCD before and after an intervention of viewing a film. Key themes from the workshops highlighted the need for the public to have more awareness about covert symptoms of OCD such as taboo obsessions and feelings of guilt and shame. Additionally, workshop participants wanted the public to know about their difficulty accessing evidence-based treatment. These data were then used to create a film, which was shown to clinicians and students. A nationwide survey was conducted to assess

clinicians' and students' knowledge of OCD before and after viewing the film.

Qualitative and quantitative data were produced as a result of the survey and provide

insight on clinicians' and students' knowledge of OCD. The main findings were that most

respondents reported having little to no formal training in OCD, which was further

supported in the qualitative data. Respondents demonstrated a general understanding of

OCD but lacked understanding of the heterogeneity of symptoms, particularly symptoms

which are not overt. This qualitative finding was supported by quantitative posttest

results wherein most respondents reported little to no knowledge of sexual obsessions;

however, the same percentage (70%) had a lot or a great deal of awareness about

stereotypical OCD symptoms. Additionally, a majority of respondents had little to no

awareness of harming obsessions. Nevertheless, the results show promise for the use of

film and client narratives as effective advocacy tools as a large majority (84%) of

respondents found the video to be at least moderately helpful in increasing their

awareness, with nearly half (47%) stating the video helped a lot or a great deal.

In the following chapter I will discuss the implications of these findings.

Specifically, I will discuss training of graduate counseling and art therapy students to

include more in-depth study of OCD, invisible symptoms of OCD, and the use of client

narratives and artwork as educational tools. I will discuss how this study contributes to

the body of knowledge related to artwork as an advocacy tool to dispel stereotypes of

mental health conditions. In addition, due to the lack of participation from physicians, I

will explore methods to educate them and discuss barriers to physician participation in

research and education. Chapter 5 also will discuss the limitations of this study, as well as

implications for further research, including conducting research on the treatment of OCD

and additional research to increase awareness of OCD.

CHAPTER 5: DISCUSSION AND CONCLUSION

Although many of the barriers that people with OCD must overcome in order to obtain accurate diagnosis and effective treatment are beyond the scope of this research study (e.g., lack of mental health care in rural areas and racial biases in mental health care), such barriers form part of the broader context for lengthy delays between symptom onset and diagnosis. It was my assertion, with support from the literature, that one significant barrier was the lack of accurate understanding of OCD by health care practitioners. Mass media, including social media, have perpetuated stereotypes of OCD, sometimes minimizing the condition as a quirk or a joke. Shame has made it difficult for many people with OCD to speak out and share their experiences of living with intrusive unwanted thoughts. Thus, there are few accurate representations of OCD available in our collective awareness.

Additionally, within the art therapy literature there is a dearth of research on OCD. Despite the skill sets that many art therapists possess, which could be advantageous in treating OCD, the field lacks research to deepen our understanding of how art therapy can be applied with this population. Initially, I had planned on conducting research about the efficacy of art therapy in treating OCD. It became clear, however, that I could not do so without first examining what art therapists and related professionals know about OCD as a starting point. Thus, I aimed with this study not only to contribute to art therapy research literature about OCD but also to build on the work of others, such as Glazier et al. (2013) and Glazier and McGinn (2015) whose studies sought to ascertain what students and clinicians know about OCD. Unique to this study,

however, is the use of direct client narratives and visual media as an educational and advocacy tool.

In this chapter I will contextualize the results of the study and discuss their implications for art therapy education and practice. I will also examine the extent to which the study addressed my research questions and purposes. Additionally, I will examine implications and need for further research, as well as the limitations of this research study. Finally, in conclusion I will offer a summary of this project for review.

Phase 1: OCD Workshops

One of the aims of the research study was to elucidate the experience of OCD. Results that emerged from the workshops with a sample of participants who had OCD were distinguished by two broad themes: the lived experience of OCD and what people with OCD want clinicians to know. Most notable was the participants' expressed experience of fear and concern about sharing OCD symptoms with health care providers. Many participants expressed worry about what would happen if they divulged their intrusive thoughts to providers. Some described actual negative experiences they had had with clinicians after disclosing their symptoms, including being misdiagnosed, feeling ashamed, and feeling as if something truly was wrong with them because they were told these thoughts were bad. Because telling one clinician was difficult enough, many participants found that it became increasingly difficult to build up the courage to continue telling others if they had had an initial negative experience. This finding underscores the importance of clinician accuracy when diagnosing OCD; if it is missed the first time it may take months or years before the individual can try to disclose their symptoms again. Although low help-seeking behaviors are not unique to OCD (e.g., psychotic disorders

also feature low help-seeking disorders; Henderson et al., 2013), it seems the shame and guilt that tend to accompany an OCD disorder, in combination with negative experiences with health care providers, make it particularly difficult to seek help.

Some workshop participants expressed anger and frustration due to their experiences of seeing several providers before receiving an accurate diagnosis or appropriate treatment. Many participants, in fact, reported feelings of catharsis from sharing this frustration with the other participants in the workshops, as well as sharing their experiences of OCD with them. For those who expressed anger and frustration with health care encounters and past treatment experiences, the workshops seemed to provide a safe space to "vent" about providers, suggesting these participants did not feel they could provide such feedback directly to the providers at the time. In some cases, participants described their vulnerability and inability to criticize a health care provider because they were a child at the time or had felt disempowered due to their vulnerable mental state and the power differential between client and provider.

As Bowie et al. (2016) described in their article reviewing unhelpful experiences in therapy, clients can be reluctant to share their negative experiences of therapy with the therapist and some clients may even blame themselves for these experiences, believing that the therapist is the "expert" and thus any challenges in therapy are the client's responsibility. Bowie et al. explained:

> Participants demonstrated their vulnerability as clients, putting considerable trust in the knowledgeable, expert therapist, thereby putting considerable power in the hands of their therapist. It would appear that they held an implicit assumption that

> their therapist was a caring professional and would therefore endeavor to assist
>
> them. (2016, p. 7)

I believe several of my research participants had similar experiences with past therapists wherein they put considerable trust in these therapists to help them, with the belief they would find some relief from their suffering while unaware that not all therapists are educated in OCD treatment even though they may be caring and empathic. Unfortunately, people with OCD seeking help may assume all therapists are educated about treating OCD due to misunderstandings about therapists' training, or they may see a therapist who has advertised or expressed confidence in treating OCD only to find that they have insufficient training and expertise.

Henkelman and Paulson (2006) described the need for therapists to initiate conversations about negative therapy experiences instead of placing that burden on the client. Recognizing that clients and counselors differ in their perceptions of the counseling experience is an important first step, with encouragement for clients to share negative feedback as a subsequent step.

Some workshop participants stated that they had never been in the presence of other individuals with OCD before; thus, the sharing of their experiences for the first time provided a space for peer validation and witnessing of their experiences. Initially, I believed there would be a healing component to the workshops due to this power of witnessing another participant's experiences. Although this may be accurate on my part, the actual phenomenon may be more nuanced. In describing the process of making a deeply personal experience public, Andrus (2017) argued that the importance of being part of a larger community may be perhaps more significant than the experience of being

witnessed. Although her work focused on women who had experienced miscarriage, I believe a similar phenomenon occurred in the workshops in my study, wherein some participants were meeting other people with OCD for the first time and thus developing a larger community, as well as seeing their experience as something larger than themselves. Both the phenomena of OCD and miscarriage are often hidden from public view and difficult to disclose to others; thus, there is power in creating a community of shared experiences.

Phase 2: Nationwide Survey

The second phase of my research study addressed two research questions: "What do clinicians and graduate students know about OCD?" and "Will their knowledge improve by watching a short film that includes narratives directly from people with OCD?" These questions were addressed through a nationwide survey of mental health clinicians and graduate art therapy and counseling students. The following will provide context and analysis for the results and discuss the pretest answers in comparison to the answers completed after watching the short film.

Summary of Pretest Results

Overall, the data from the pretest portion of the survey suggest that clinicians and students may have a general understanding of OCD but without understanding of certain key features related to diagnosis and treatment. This finding supports results of other studies as well. For example, Glazier et al. (2013) found that therapists and psychologists were able to accurate identify OCD at a rate of 84% when given a vignette about someone with contamination OCD symptoms but 77% misidentified OCD when given a vignette about an individual who was obsessed with the fear he might be gay. Similarly,

in this study, few respondents acknowledged invisible symptoms of OCD (e.g., mental rituals, taboo thoughts, shame, etc.). Additionally, recommendations for, or awareness of, evidenced-based treatments such as ERP were minimal. However, there did seem to be an understanding and awareness of the repetitive, incessant nature of OCD and common symptoms such as contamination, ordering or arranging objects, and repeatedly checking objects. Clinicians overwhelmingly expressed a desire to be empathetic and compassionate toward clients with OCD. Looking in more detail at the answers to two pretest questions, "Please describe a typical client with OCD whom you've treated or know of" and "Have you received formal training about OCD?" supports the finding that respondents had general knowledge of OCD but generally lacked specific understanding of common symptomology.

With regards to the prompt to describe a client or someone they knew with OCD, a prominent response distilled from the data was that respondents had not worked with anyone or did not know anyone with OCD. This result is notable due to the prevalence of OCD. It seems unlikely that respondents haven't had at least some exposure to someone with OCD, but perhaps they were unaware of this due to the invisibility of symptoms or due to their inability to characterize another's experience as OCD. This response further supports the hypothesis that clinicians lack awareness about common OCD symptoms. Similarly, Coles et al. (2013) found in their study of 577 adults who were given vignettes of OCD symptoms, that only 33% were able to correctly label the disorder as OCD. That many respondents in my study answered the question with a stereotypical understanding of OCD, such as mentioning someone who cleans or washes their hands excessively, also points to a general understanding. Given that very few respondents mentioned intrusive

thoughts or specific types of obsessions, a broader awareness of OCD appears to be needed among these participants.

The extent of the study sample's formal training in OCD validated the need for such training. Despite that 70% of clinician respondents and 74% of graduate student respondents reported having little to no formal training in OCD, nearly 45% of respondents self-rated their knowledge of OCD as moderate. This finding is consistent with that of Glazier and McGinn's (2015) research that assessed the ability of doctoral students to identify OCD based on vignettes. In their study, 82% of respondents said they were somewhat or very knowledgeable about OCD. However, the respondents' ability to accurately diagnosis OCD based on the vignettes suggested a large discrepancy between perceived knowledge of OCD and actual awareness of OCD subtypes. These findings, as well as the findings in my study, point to an inflated sense of confidence about OCD that is not founded in actual knowledge. That is, clinicians and students may think they know more about OCD than they actually do or may not want to admit to a lack of knowledge.

The absence of formal training in OCD was not surprising to me, given my own experience. I received minimal training on OCD in graduate school and completed nearly all of my formal training on diagnosis and treatment of OCD after receiving my master's degree. Implications on graduate training and pedagogy will be discussed below; however, these results are consistent with the other pretest results and consistent with results in the literature.

Summary of Posttest Results

The posttest results illuminate several issues relevant to the OCD community and health care practitioners. First, the data depict a cohesive narrative that many students and

clinicians have a general understanding of OCD but are unaware of specific symptoms—particularly symptoms related to obsessional OCD such as taboo intrusive thoughts and the experience of guilt and shame. Second, the use of a film to share narratives directly from people with OCD was an effective tool to increase awareness and understanding. This finding builds on the work of Glazier and McGinn (2015), who found that doctoral psychology students' ability to correctly identify OCD improved after watching a brief film. After watching the film in my study, the majority of respondents reported increased awareness of specific OCD symptoms and reported more compassion and insight into the experiences of people with OCD. However, the video was reported to be less effective in improving skills in diagnosis and was minimally effective in educating others about appropriate treatment for OCD. Although the focus of the video was not about treatment, improved awareness of specialized treatments such as exposure therapy and response prevention was indicated as well as the need for referrals if clinicians lack sufficient training. The following will discuss examples from the survey that support these findings.

Comparison of Pretest and Posttest Results

By comparing the pretest results to the posttest results, there are several important findings. One notable finding has been discussed above: The pretest results indicate lack of deep knowledge of OCD and tend toward superficial knowledge, which was further supported by comparing answers from the pretest to the posttest. Second, the use of a brief film with personal narratives by people with OCD appears to be a useful tool in educating practitioners about the experience of OCD.

As one way to assess clinicians' and students' knowledge, survey participants were asked to write up to five words they associate with OCD before and after watching

the brief film. "Anxiety" and "anxious" were the words that occurred most frequently in the pretest responses. Anxiety is commonly seen in OCD and can be a prevalent feature of the condition (APA, 2013), so this is an accurate term to associate with OCD. However, many of the workshop participants described initially receiving a diagnosis of "anxiety," given that it was a prevalent symptom of their OCD and explained that because the diagnosis was not specific it did not lead to effective treatment or fully explain their experience.

From a diagnostic standpoint, OCD is no longer categorized as an anxiety disorder within the *DSM-5* but rather is now classified within the category of obsessive–compulsive and related disorders (APA, 2013). There are potential harms that may occur due to misdiagnosis or lack of specificity in diagnosis. In Glazier et al.'s (2014) study of primary care physicians who assessed vignettes of OCD subtypes, those who misdiagnosed these vignettes assigned diagnoses of schizophrenia, obsessive–compulsive personality disorder, and sexual identity confusion. Other physicians misdiagnosed the OCD vignettes with conditions similar to OCD such as Tourette Syndrome and specific phobias. Some of these diagnoses, such as schizophrenia, have vastly different treatment approaches than OCD; thus, the importance of accurately identifying OCD, with specificity, may lead to improved treatment outcomes. The label or diagnosis of anxiety, as seen in my study, without further specificity of symptoms could lead to insufficient or ineffective treatment.

The respondents' choice of the words "obsession compulsions," "obsessive compulsive," "obsessions," and "compulsions" was also prevalent in the results. Although these words are included in or are derivatives of the name "obsessive–

compulsive" disorder, their prevalence suggests that clinicians and students may not have a deep understanding of their actual meaning or definition. This is similar to describing major depressive disorder using the word "depressed." Although accurate, it does not speak to a specific understanding of the condition.

These results provide unique insight into the associations that clinicians and students have with OCD and supports literature that suggests harms can occur when clinicians attempt to treat clients without knowledge of the nuances of condition and specifically without knowledge of a client's lived experience (see, e.g., Bruce et al., 2018; Steinberg & Wetterneck, 2017; Storch, 2015). Thus, the need to connect clinicians with the human experience is essential for accurate diagnosis and evidenced-based care. Despite clinicians' desires to be empathetic and nonjudgmental toward clients this is not enough to provide sufficient relief from the suffering of OCD.

Implications for Art Therapy Education and Practice

The study has several implications for art therapy education and practice. Below I will address issues related to pedagogy and graduate training of art therapists, ethical issues of importance related to this study, and the implications of incorporating advocacy into art therapy treatment.

Pedagogy and Graduate Training

Based on the survey results, most respondents received most or all of their training about OCD in graduate school and overall had only a general understanding of OCD without the more precise knowledge needed for accurate diagnosis and treatment. Thus, there may be a need for additional exposure to OCD at the graduate level. This observation conforms with results of a national survey of 221 graduate psychology,

psychiatry, and social work programs that evaluated the need for training in evidence-based treatments such as cognitive behavioral therapy, finding that the majority of programs had no requirements for didactic training or supervision on this topic (Weissman et al., 2006). The general awareness and lack of nuanced knowledge suggest it would be beneficial to provide additional training on OCD, either in graduate school or through post-graduate training, to prepare clinicians for working with clients who have this disorder.

The primary purpose of professional accreditation of programs in the U.S. is to ensure that graduate clinical training meets minimum standards for entry into the designated profession. At present, the Commission on Accreditation of Allied Health Educational Programs is the accreditation body governing art therapy graduate programs and the Council for Accreditation of Counseling and Related Educational Programs is the primary accreditation body for mental health counseling programs. Although they provide general standards for the education of mental health conditions, graduate programs are often designed to equip clinicians with a broad range of clinical skills rather than in-depth training. According to McHugh and Barlow (2010), successful training of evidenced-based practice requires the combination of didactic training and competence training, which they defined as the process of acquiring skills to administer treatment with skill and reliability. For graduate schools to effectively train students in the treatment of OCD, didactic training alone arguably is insufficient; outcomes are greatly improved with the combination of supervision to enhance competence training (McHugh & Barlow, 2010). Competence training is best delivered by experiential learning such as

role plays, direct work with clients, review of taped sessions, and consultation with supervisors (McHugh & Barlow, 2010).

In cases where in-depth training in graduate school on OCD may not be feasible, increasing the students' exposure to OCD, particularly through client narratives and/or treatment experts, may be a relatively effective way to improve clinicians' understanding and empathy toward OCD. As one survey respondent wrote, "My peripheral knowledge of OCD is anecdotal and loose. Seeing visuals along with the personal stories of clients' stories will create a more concrete profile in my mind and help identify and work with clients in the future." Possibilities for bridging the gap between graduate students and people with OCD include exposure to artwork made by people with OCD, hearing direct narratives from those with the condition, and guest lectures by OCD specialists. As this study suggests, even a brief 8-minute video demonstrates the potential for improved awareness through this means.

Therapists' reservations about evidenced-based treatments such as exposure response prevention therapy (ERP) are also a significant barrier to people with OCD receiving effective treatment. Deacon et al. (2013) found that PhD-educated clinical psychologists had more positive attitudes about the use of ERP for OCD and anxiety disorders than their peers with master's degrees. These authors hypothesized that there may be differences in training on evidenced-based practices within doctoral programs as compared to master's programs. Of particular relevance to this discussion is their finding that exposure to evidenced-based practices in graduate training may increase the use of these practices; specifically, the authors found that didactic training on ERP improved

knowledge and positive attitudes about this treatment significantly for clinicians of all education levels.

Another issue related to graduate training and OCD is the need to recruit more practitioners into this specialty. In my own experience, I was not aware of this treatment specialty while I was in graduate school and certainly did not expect that I would become passionate about it. Students I have taught in courses about OCD have endorsed similar views. Many told me they were unaware of the treatment specialty and had never considered this area of practice. Other students have said that although they did not want to work with the OCD population, their additional training would help them be able to more accurately diagnose and refer clients to a specialist if they encounter OCD in clinical practice. These anecdotal reports from students emphasize the importance of increasing their exposure to OCD as a means of motivating an interest in working with this population or to ascertain that one's interests lie elsewhere, with both outcomes being beneficial for clients with OCD.

As previously described, a significant barrier to treatment is the lack of appropriately trained providers, especially in rural areas (Jensen & Mendenhall, 2018; Reid et al., 2017). Increased exposure to OCD in graduate school and the use of technology to provide virtual case consultation and trainings may increase the number of clinicians who seek out this niche and consequently improve treatment opportunities in geographic other areas of need.

Supervision

In my own experience I lacked access to supervisors who specialized in OCD as I was pursuing my licensure in this field; however, my work and training in a specialized

treatment center with oversight by experts compensated for this need for specialized supervision. Supervision is required for licensure and is utilized throughout one's career; as a useful resource in case consultation and remediation, it is an important resource for educating practicing therapists on topics not covered in graduate training. Given the lack of OCD specialists, it seems likely there is also a lack of supervisors who specialize in OCD treatment. Additionally, results of my study showed the majority of respondents received training on OCD in graduate school, but their knowledge was general and often insufficient to meet the needs of these individuals. Expanding access to diagnosis-specific supervision and consultation may be an effective way to remedy gaps in education and support therapists working with this population who may not be able to receive on-the-job training.

This suggestion, that there is value in combining didactic training and supervision in supporting early career professionals implementing evidenced based practices, has been proposed for cognitive behavioral therapy in particular. For example, Rakovshik et al. (2016) found the combination of internet-based training on CBT with supervision to be more effective than internet-based training alone. Interestingly, a majority of participants in their study reported having no CBT skills prior to the training. In a similar study, Solem et al. (2009) explored the use of didactic training and supervision specifically focused on ERP with counseling students, none of whom had prior clinical experience treating OCD. They found that a majority of patients receiving treatment from these students achieved clinically significant improvements by the end of the study. Importantly, the supervisors all had expertise in OCD treatment and research, suggesting the efficacy of expert-led supervision. Supervision therefore may be key in supporting

clinicians who desire to treat those with OCD but did not have sufficient training in the disorder while in graduate school.

Ethics of Practicing Within One's Scope

The results from this study highlight the importance of treating clients within one's scope of practice, as many workshop participants stressed the harm they experienced as a result of clinicians overstating their confidence in working with OCD. Art therapists and counselors are bound by their respective bodies' codes of ethics to determine ethical practice. For example, according to the art therapy code of ethics (Art Therapy Credentials Board, 2019), "art therapists shall assess, treat, or advise only in those cases in which they are competent as determined by their education, training, and experience" (p. 3, Section 1.2.3). Similarly, the American Counseling Association's (2014) ethics code states that counselors may practice "only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (2014, p. 8, Section C.2.a) and those who "practice in specialty areas new to them only after appropriate education, training, and supervised experience" (p. 8, Section C.2.b).

This study confirms the negative treatment experiences the participants have had with providers who promoted themselves as having knowledge and competence in treating OCD despite that they did not have specialized training or expertise to treat the condition. However, some survey respondents reported that they would not advertise that they treat OCD as a result of participation in this study, which is a successful outcome of the study. Results from this study support Franklin et al.'s (2013) claim that specialized training and skills are needed for OCD treatment to be effective. The condition is

treatable with effective treatments such as ERP (APA, 2007; Koran & Simpson, 2013; Ponniah et al., 2013) and/or medications (Foa et al., 2005; Franklin & Foa, 2011); however, but due to the paucity of specially trained providers, people with OCD may have difficulty finding an OCD specialist.

Validation by my study's survey respondents of the importance of practicing within one's scope should not be viewed as a surprising result. Spotts-De Lazzer and Muhlheim (2016) identified similar challenges in the need for specialized knowledge and skills to treat eating disorders. Eating disorders, which share many similarities with OCD, require deep knowledge of assessment and diagnosis, nutrition, medical issues that may arise, evidenced-based practices, and collaboration with multidisciplinary teams. These authors argued that competency in treating eating disorders is usually developed outside of scope of a typical therapist's training, especially when therapists are left to decide for themselves if they are qualified treat these complex disorders. Accordingly, an alternate solution is to develop a standard body of initial knowledge for clinicians to obtain competence and differentiate themselves from generalists. A similar approach may be beneficial for OCD providers, and specialists among art therapists in particular, as a means of establishing baseline competence in diagnosis and treatment.

It is possible that some clinicians, particularly those in private practice, feel the need to advertise a variety of conditions they treat in order to attract enough clients to sustain their practice. Additionally, therapists in rural or other areas may feel substantial pressure to treat a variety of conditions due to lack of specialized providers. As Wise (2008) noted, there can be significant tension between the need to practice within one's area of competence and the desire to meet the emergent needs of communities served.

People seeking help do not need additional burdens; they need to be able to trust clinicians' representations of their knowledge and expertise.

This research study raises additional implications for how best to educate consumers and clinicians alike to make it easier for people with OCD to find help. In Baer and Minichiello's (2008) study surveying individuals with OCD and their help-seeking behaviors, nearly a third of respondents stated they were not aware of specialized treatment as an option and another third believed such therapy would not help. Although conditions may have improved in recent years, my research study supports Baer and Minichiello's findings from over a decade ago: There is still work to be done on educating the public about effective treatments for OCD. Based on the lived experience of the workshop participants, clinicians who believe they are practicing within their scope may be inaccurately diagnosing clients, such as treating them for generalized anxiety or depression, which may delay treatment for the client's OCD. These situations highlight the need for clinicians to be informed about OCD or seek consultation in order to provide accurate diagnosis. Based on the survey results, it appears that clinicians are well intentioned and generally have a strong desire to be compassionate and helpful with their clients but may lack knowledge; thus, any obstructive actions that hinder accurate diagnosis and treatment likely stem from a lack of knowledge, not malevolence.

Another result of this research study was the increased likelihood reported by the clinicians that they would refer clients to an OCD specialist due to increased awareness about OCD and their lack of knowledge about treatment for this condition. As one student respondent wrote, "Once I am a clinician, I would honestly refer my patient since . . . [there] . . . are clearly others that want to center in on OCD as their population."

According to the American Counseling Association's (2014) code of ethics, counselors are required to terminate services and provide appropriate referrals if the counselor lacks competence to treat the client (p. 6, Section A.11.a). This is not always a straightforward decision, however. Some symptoms may not initially appear or be discussed until farther along in the therapeutic relationship. Additionally, clients seek therapy for a multitude of reasons and therapists may have competence in some, but not all, of these areas. Consultation with other therapists, especially specialists, may help counselors and art therapists navigate the decision to provide referrals.

Art-Based Advocacy and Treatment

This study offers several implications for art therapy practice. The research presented here contributes to the body of knowledge that suggests public viewing of artwork and hearing personal narratives can increase understanding and empathy toward people with mental health conditions (Koh & Shrimpton, 2014; Potash & Ho, 2011; Yamauchi et al., 2011). Thus, in certain situations art therapists may consider advocacy as a treatment goal. In my view, an important aspect of recovery is making meaning from the experience of living with a mental health condition. Meaning making, often done by constructing a narrative, is frequently a goal in therapy (e.g., White & Epston, 1990). However, when meaning making by the client is taken beyond the private realm of the therapy room and offered for public consumption (e.g., posting art and narratives in a public-facing advocacy website, mounting informative art exhibitions, etc.), there may be several benefits. As Nurser et al. (2018) described, personal storytelling can be a cathartic experience for those living with a mental health condition and a way to increase empowerment. Sharing these stories with others can foster a sense of belonging for the

individual while providing hope for others who hear and reflect on those stories (Nurser et al., 2018). However, more research is needed on how client readiness for public disclosure is assessed and the possible harms that may occur without such guidelines.

Additionally, the results of the workshops from this study demonstrate the desire of people with OCD to communicate their experiences to others while the survey results demonstrate a need for helping professionals to understand these experiences. Art therapists may be situated to bridge this gap through art-based methods of advocacy and storytelling. Similar to how film was used in this study is the potential of auto-videography, which is the self-documentation of one's experiences via videos that may be shared with the public. This medium can be an effective way to convey accurate representations of mental health conditions to combat stereotypes and thus educate the public (Linz et al., 2016; Petros et al., 2016). Research by Linz et al. (2016) and Petros et al. (2016) supports the notion that film can combat inaccurate stereotypes and increase representation, which was an important component of this study as well. By hearing directly from people with OCD in this study, survey respondents reported new awareness of symptoms and challenged their previously held stereotypical views of OCD that tended to be centered around symptoms of cleanliness and orderliness. As noted in the literature review, stereotypical representations of OCD are perpetuated by social media and television, potentially contributing to clinicians' limited understanding of OCD. The use of film, as was seen in this study, may be a way to foster "aesthetic empathy" (Wix, 2009); that is, a method of portraying one's direct experience in a way that fosters empathy among viewers and allows for viewers to witness a person's true lived experience as compared to stereotypes.

Digital storytelling or autovideography, as a demonstrated potential of my study, can serve several purposes and may produce multiplying impacts that start from the internal experience of the research participants and ripple out to the external community. These impacts include raising awareness of the need for providing a safe, therapeutic space for marginalized communities to construct and have their own narrative reflected; providing a more nuanced understanding of the lived experience of people with mental health conditions to researchers, clinicians, and the wider community; and offering a tool for public health reform (Gubrium, 2009). Sharing personal narratives through film has great potential to bridge the gaps between consumers, clinicians, and the public and to promote "a recovery orientation that is based on empathy, community and solidarity between stakeholders" (De Vecchi et al., 2016, p. 191). The aspect of solidarity may be particularly relevant for this research study. Given that many workshop participants reported unhelpful therapeutic experiences and anger toward clinicians, there may be a need for reconciliation to repair these breaches of trust between consumers and providers and to lessen the divide between clinicians and their clients.

As depicted in Figure 1, in addition to centering advocacy as a treatment goal, art therapists may be uniquely situated to treat OCD, given the experiential nature of treatment (ERP) and the skills and training inherent to art therapists in facilitating experiential therapy. Due to the heterogeneity and specificity of a person's OCD obsessions, it is essential for OCD specialists to be creative in their development of exposures for each client. An art therapist's knowledge of art media, in combination with knowledge of OCD and ERP, would be an advantageous skill set that would incorporate

creative, art-based solutions for exposures. Conversely, art therapists could enhance their knowledge and skill set in collaboration with OCD specialists.

The survey results showed a lack of formal training in OCD among clinicians and students; therefore, increased collaboration with OCD specialists to gain skills in assessment, diagnosis, and treatment could greatly enhance an art therapist's ability to provide effective treatment. As Reid et al. (2017) found in a study of 230 practicing clinicians who treated anxiety disorders, nearly half (48%) stated that a lack of training was the primary reason they did not provide ERP to clients where it was therapeutically indicated. However, another study demonstrated the efficacy of a day-long, didactic training session on ERP to significantly improve ERP (Deacon et al., 2013). Art therapists and OCD specialists, in collaboration, might enhance each other's skill sets to improve treatment delivery while also working toward the shared goal of increasing advocacy and public awareness of OCD. Although this study's main focus was not on treatment, the results demonstrate potential for art therapists to utilize their expertise in the use of art making and storytelling as advocacy tools. There is tremendous potential to combine this skillset with expertise from OCD specialists to improve mental health literacy of the public, which fills a significant need within the OCD community.

Limitations of This Study

One limitation of this research study is the sample size and heterogeneity of the survey respondents. Although the first phase of the study involved only eight participants with OCD, this sample was appropriate for capturing rich, relevant qualitative data to illuminate the lived experience of OCD. However, a larger and more diverse sample for the national survey would have increased the potential generalizability of the

respondents' results. Gathering more detailed demographic information would have provided more data to examine the influences of geographic locations or years of practice experience on the result and provide additional context.

For this study, the purpose was centered on advocacy and not generalizable findings regarding respondents' attitudes, thus, a fully representative sample for each of the three target populations was not necessary. Utilizing a convenience sample was appropriate, given the nature of this study as a pilot study. Results could be tested in the future with other, more representative sampling.

Additionally, the difficulty in recruiting a sufficient sample of physicians for the survey meant that results from this group were statistically insignificant and therefore were removed from the data set. This challenge is not unique to my study. Unertl et al. (2018) described several reasons physicians are reluctant to participate in research, including the belief that the research will not directly impact their clinical practice, despite evidence that suggests patients are seeking mental health care through primary care physicians at high rates (Oyama et al., 2012). A second reason, according to Unertl et al., is the time constraints physicians experience. Primary care physicians may be interested but reluctant to participant in a study due to the need to protect their time and maximize time spent with patients. For my study, I had several physicians express interest, but few followed through with my requests.

Another limitation of this study is that the results were complicated by the dual purpose of the research design. The goal of the pre/post test design was twofold: to provide advocacy and also provide information for providers. Through data analysis, it was apparent that the film was an effective tool in assessing practitioner knowledge and

providing some information to providers, although the survey was less effective at measuring advocacy. Additional research is needed on effective strategies to increase advocacy.

Areas for Future Research

Although this study builds on existing research in the field of psychology (Glazier & McGinn, 2015), to my knowledge it is the first study on OCD within art therapy. Thus, there are numerous areas for future research. As a starting point, replication studies could be useful to determine if the findings in this study are consistent across diverse or larger samples. It would be interesting to see if similar themes would occur with another group of people with OCD and if the results of surveying a different group of clinicians would be similar. As I have noted, I had intended to include physicians in the nationwide survey and believe this is an area for additional research. Respondents to the survey included three psychologists and a few doctoral-level art therapists, but nearly all of the clinicians were master's level. It would be interesting to do additional research to the extent to which professional and higher-level training leads to increased knowledge of OCD as compared to master's level art therapists and counselors.

This study focused on assessing knowledge of OCD and did not include an in-depth focus on clinicians' knowledge of how to treat OCD. I believe this is a significant area of study, particularly within the field of art therapy. It may be helpful to conduct studies to assess how art therapists are currently treating OCD. Additionally, it is my belief that art therapy may be beneficial for people with OCD when used in conjunction with evidence-based treatments such as ERP, but such studies do not exist to examine the efficacy of art therapy with this population.

Another important area for future research is the need for qualitative studies on OCD. Through my review of the OCD literature, it was my impression that existing research tends to favor a quantitative paradigm. This focus has resulted in considerable advances over the past several decades, including evidence-based treatments and a significant increase in knowledge about the etiology of the disorder. However, as a result of privileging certain information and certain types of research questions, other data may be lost or ignored. This is consistent with the view that Arbesman et al. (2008) noted of the single-hierarchy of evidence that places value on randomized controlled trials, meta-analyses, and controlled outcome studies over other types of research. In many cases equally important data from qualitative or performative data is marginalized or devalued. Increasing the diversity of the types of studies can provide practitioners with richer, more comprehensive data with implications for practice.

Tomlin and Borgetto (2011) argued that the hierarchy of evidence does not meet the demands of clinicians who must integrate research into the complex physical, social, psychological, and spiritual factors of each client, thus perpetuating a gap between clinicians and their connection to a client's lived experience. The type of information gained from well-designed clinical trials, although valuable and important, is not necessarily the information that is needed to address particular client needs. There is a gap between evidenced-based research and clinical practice, which could be closed with research that places emphasis on collaboration with clients and privileging their lived experiences. Furthermore, "certain research questions of crucial interest to the profession can only be answered by certain methods of research. There is no gold standard of research design for answering all questions of importance" (Tomlin & Borgetto, 2011, p.

195). As an example, it may be important to learn more about individuals' negative experiences with therapy in order to improve clinical practice. This type of question requires collaboration with clients and likely would best be answered within a qualitative or performative framework.

To be clear, quantitative research on OCD has contributed to significant advances in treatment and this perspective is needed. However, it would benefit stakeholders (people with OCD, clinicians, researchers, etc.) to conduct research outside of the quantitative paradigm. As Tonelli (2001) wrote, "empirical evidence, no matter the quality or quantity, even with the incorporation of patient values and preferences, will never be sufficient to determine optimal clinical practice" (p. 1439). As an example, a similar study to mine could be conducted using a different method such as participatory action research (Kapitan, 2018) to include people with OCD as co-researchers. To my knowledge there are no studies on OCD using this methodology. Such a collaboration between people with OCD and researchers could help bridge the gap between lived experience and practice.

Arts-based research could offer additional data that are missing from the OCD literature. To my knowledge, this study is the first of its kind to incorporate art media in systematically exploring the experience of OCD and assessing the impacts of sharing this information with the public. Singh and Jones (2012) explored the importance of visual media in research in their study on compulsive hoarding, a condition considered to have many similarities with OCD. These researchers noted the lack of knowledge surrounding the lived experience of compulsive hoarding and found that participatory photography elucidated the phenomenon while adjusting the power differential between participants

and researchers. Arts-based research, used alone or in conjunction with participatory action research, is an area rich with research opportunities and may bridge several gaps: between researchers and participants, between the art therapy community and the OCD community, and between consumers and clinicians.

Summary

The results of this study provide several key findings. The workshops illuminated the lived experience of OCD, including hidden symptoms of distressing thoughts, shame, and guilt. They also shed light on participants' negative experiences with health care providers and difficulties accessing accurate diagnosis and treatment. An unintended result of these workshops was participants' ability to develop community with other people with OCD based on similar life experiences, and to be witnessed and seen. The healing function of being witnessed by others further underscores the results of these workshops: People with OCD often suffer in isolation and need increased public visibility.

When the experiences of the workshops were video edited into a film and presented to a public arena, along with a pre/post test survey designed for mental health clinicians and graduate counseling and art therapy students, several findings emerged. Graduate students and clinicians in general were aware of the more overt symptoms of OCD, such as excessive cleaning or other repetitive acts, but were less aware of covert symptoms such as repugnant thoughts, guilt, or mental rituals. After viewing the film, most respondents reported increased awareness and understanding of the heterogeneity of OCD and the need for specialized treatment. This finding suggests that seeing or hearing

directly from people with OCD can be an effective tool for shifting attitudes and perceptions, and for educating treatment providers.

This research study has several implications for art therapy practice and future research, as well as for art therapy pedagogy. Most survey respondents stated they received most or all of their education about OCD in graduate school. There are several opportunities to improve exposure to OCD in graduate school, including the use of a brief film like the one used in this survey. Hearing directly from people with OCD and seeing their artwork provides a richer description of this condition than can be provided through reading the *DSM-5* or traditional lecture format. Beyond graduate school, increasing access to OCD-specific continuing education and via mentorship and supervision are other important methods for increasing clinician education and awareness of this disorder. This is particularly important because there are few internship or employment opportunities for recent graduates to receive in-depth training on OCD due to the limited number of OCD-specific treatment facilities.

Within art therapy practice, this study contributes to the body of knowledge that suggests advocacy and public sharing of one's experience may be a beneficial therapeutic goal for some clients with mental health conditions. Public sharing may have several positive outcomes for clients, including the experience of catharsis and the ability to make meaning from their suffering. As indicated in the workshops in this study, shame was a key feature of the OCD experience. Public sharing, even within a community of peers, may be one method to reduce this shame by taking away the power of intrusive thoughts by making them public instead of secret and seeing one's suffering as part of the common human experience.

This study adds to the limited body of literature on arts-based methods of advocacy for people with OCD. The study shed light on the true lived experience of someone with OCD, an image rarely seen through media or in graduate school curricula. Additionally, the study bridged a gap in clinical practice between people with OCD and mental health clinicians. The results of the study (disseminated through a mixed-media website) have the potential to reach anyone in the world and offer insight into the experience of having OCD. Access to this knowledge may have impacts for people with OCD, their family members, clinicians, and the broader community. For people with OCD this information may reduce stigma, increase access to care, and reduce isolation. For physicians and mental health clinicians these data may assist in improving rates of recognition and accurate diagnosis. Graduate art therapy and counseling students may develop increased awareness of the disorder and increased interest in working with this population to fill the need for clinicians with specialized training, especially in rural areas.

The results from this study are a starting point for additional research on OCD and art therapy. Future studies assessing art therapists' knowledge of OCD treatment and potential benefits of art therapy in the treatment of OCD are needed, as are studies within a qualitative and performative paradigm.

Bridging the gap between a client's lived experience with OCD and a clinician's knowledge is still a problem of high priority within the OCD community due to the lengthy wait times for treatment and accurate diagnosis as well as the potential harms that occur due to misdiagnosis. However, by supporting those with lived experience in

sharing their artwork and narratives this becomes a potent tool to connect clinicians to the

heterogeneity and suffering of OCD.

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Appendix A

Informed Consent Form for Workshops

Consent Form for Research

PROTOCOL TITLE: Illuminating the Phenomenon of OCD through Imagery and Writing

PRINCIPAL RESEARCHER: Erin Headley, MS, LPC, ATR-BC

SUPPORTED BY: Mount Mary University

Background:

This study will examine the experience of individuals with obsessive-compulsive disorder (OCD). There are misconceptions about this disorder among the general public. These misconceptions can contribute to several difficulties for a person with OCD including experiencing shame, receiving appropriate diagnosis, and accessing effective treatment. Participation in the study will help to educate the public about this disorder. Through the use of art, writing, and interview questions participants will communicate their experience of having OCD. This data will be shared anonymously with physicians, students and mental health clinicians to explore whether or not this increases public understanding about OCD. Additionally, if you choose, some of this data may be displayed anonymously on a multimedia website to help educate the public in order to reduce misconceptions and stereotypes about OCD.

What is the Purpose of this Study?

You are being asked to take part in a research study. This form has important information about the reason for the study, what you will do, and the way I would like to use information about you if you choose to be in the study.

The purpose of this study is to explore how art and writing can be used as a tool to educate the public and increase awareness about OCD. The study will include art works, writing, and interview excerpts by people with OCD which will be presented to physicians, graduate students and other clinicians and may eventually be made public on a multimedia website.

What will I Do if I Choose to be in this Study?

You will participate in a 3-hour workshop with other people with OCD. You will be asked to create an image, complete some writing about your image, and participate in a semi-structured group interview. The workshop will be audio recorded. Participants will decide as a group what, if any, images, statements, and/or writing samples are representational of the experience of having OCD and what they would like to share

with the public. Individuals may opt to have their data shared publicly on a website. This is completely optional and not required to be a participant of the study. Upon completion of the study you will also be asked to review the researcher's findings to determine if they are accurate to your experience.

The purpose of these procedures is to collect data that will be used to educate others about the impact of having OCD, to accurately describe the phenomenon of OCD, and to potentially dispel stereotypes about OCD.

What are the Possible Risks or Discomforts?

Your participation will involve creating and discussing artwork and/or stories on your experience with OCD. This may become uncomfortable or bring up feelings or thoughts you may not be aware of.

This information will be displayed to the public. Outside groups such as physicians, art therapy graduate students, and other mental health clinicians may view artwork and read writing samples and interview excerpts. Although this information will be displayed anonymously without direct identifiers, this may also create discomfort.

What are the Possible Benefits for Me or Others?

The possible benefits to you from this study include deepening your understanding of yourself and your knowledge and experience. You may also experience reduced isolation as you communicate your experiences to others with OCD within the workshop.

This study will contribute to the public's knowledge and understanding of OCD. This may help people with OCD feel less shame and stigma about the disorder and feel more understood. Increased knowledge about the disorder may improve access to effective treatment.

This study will add to the academic literature around OCD. The intent of the study is to educate students and clinicians about the disorder. It could benefit students in training to learn about important considerations when practicing art therapy with people with OCD, including accurate diagnosis.

Dissemination

Some of the information from this workshop will be shared with physicians, graduate students, and other mental health clinicians. These groups will complete a survey to determine if this information increased their knowledge and understanding of OCD.

If you so choose, data produced from the workshop may be also displayed on a multimedia website.
The final website may include the following:

- Photographs of artwork created by people with OCD
- Writing excerpts created by people with OCD
- Excerpts/quotes from semi-structured interviews from people with OCD
- Information about the study including its purpose and procedures
- Information about OCD including treatment resources, facts about the disorder, etc.

Once the website is complete, it will be viewed by an OCD expert and research advisor before it is published. Once published the website will be available to anyone as a tool to increase awareness and education about OCD. The researcher will also write a contextual essay summarizing the findings from this research. The researcher intends to present data and findings from this research study to audiences which may consist of art therapists, counseling students in training, and professionals at conferences, trainings and symposia. The audience could range from individuals who have experienced OCD to physicians such as primary care doctors and OB/GYNs to students learning how to practice art therapy and counseling.

Financial Information

Participation in this study will involve no cost to you.

What are my Rights as a Research Participant?

If you choose to be in this study, you have the right to be treated with respect, including respect for your decision whether or not you wish to continue or stop being in the study. You are free to stop being in the study at any time. If you choose to stop being in the study after images and writing are published on the website, all images and writing will be removed but it cannot be guaranteed that this content does not exist on other sites which are not affiliated with the study. You also have the right to not answer any question in the interview portion of the workshop. You may also opt-out of art making and/or writing at any time during the workshop.

If you have any questions about this study, please feel free to contact me [REDACTED] If I am not immediately available, I will return your call as soon as possible. If you wish to speak with my research advisor, Dr. Chris Belkofer, he can be reached at [REDACTED]. If you have concerns regarding your privacy and rights, you may contact Mount Mary University IRB chair, Dr. Tammy Scheidegger, [REDACTED].

What about my Confidentiality and Privacy Rights?

Participation in this research study may result in some loss of privacy, since persons other than the researcher might view your study records, which may include my research advisors, outside reviewer(s), and an outside OCD expert. No identifiable information will be shared with these individuals or on the published website.

All artwork and writing will be stored in a locked cabinet in my office. Electronic information such as photographs of artwork and the audio recording of the workshop will be contained on a password protected iPhone and MacBook.

Consent

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form after I sign it.

_____ (initial) I agree to allow my artwork and writing to be used for this study.
_____ (initial) I agree to be audio recorded during the workshop

I give permission for my artwork, writing samples, and/or written interview excerpts to be used on a public website.   ____YES   _____NO

_____
Signature

_____   _____
Subject's Name (printed) and Signature   Date

_____   _____
Name (printed) and Signature of Person Obtaining Consent   Date

_____   _____   _____
Witness (Print)   Witness (Sign)   Date

Appendix B

Survey Instrument

Assessing Clinician and Student Knowledge of Obsessive-Compulsive Disorder

Consent Form

The purpose of this research project is to assess practioner and student knowledge of Obsessive-Compulsive Disorder (OCD). This survey is part of a research study being conducted by Erin Headley, LPC, ATR-BC at Mount Mary University.

Your participation in this research study is voluntary. You may choose not to participate. If you decide to participate, you may withdraw at any time. If you decide not to participate you will not be penalized.

You will be asked to complete an online survey and watch a brief video. This process should take approximately 20 minutes. Your responses will be confidential and protected using a password protected electronic format. There are no known risks to participating.

If you have questions about the research study please contact my advisor Dr. Emily Nolan (███████████) or the IRB Chair Dr. Tammy Scheidegger (███████████). This research has been reviewed and approved by Mount Mary University's IRB for research involving human subjects.

* 1. By checking yes, you have read the consent form above and agree to be a research participant in this study.

☐ Yes

☐ No

Next

* 2. Please select the role that best describes you

✓

Mental Health Clinician--ATR or ATR-BC
Mental Health Clinician--LPC/LMFT
Mental Health Clinician--ATR & LPC/LMFT
Mental Health Clinician-- Master's degree/Unlicensed
Psychologist
Art Therapy Graduate Student
Counseling Graduate Student
Physician-Primary Care
Physician-Specialist
Other
No response

Other (please specify)

* 3. Have you received formal training about Obsessive-Compulsive Disorder (OCD)?

○ None at all

○ A little

○ A moderate amount

○ A lot

○ A great deal

For all answers other than none at all, please describe

* 4. How would you rate your knowledge of OCD?

○ None at all

○ A little

○ A moderate amount

○ A lot

○ A great deal

* 5. Please describe a typical client with OCD whom you've treated or know of.

* 6. Based on your knowledge, what symptoms characterize OCD?

* 7. What do you feel clients with OCD need from you as a clinician?

* 8. Please write up to 5 words that you associate with OCD

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Please watch the following video before continuing with the survey:
https://www.youtube.com/watch?v=-bJ1fg7ALF8&feature=youtu.be

* 9. Once you've watched the video, please select yes to continue with the survey

○ Yes

○ No

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* 10. How would describe OCD to another clinician?

[   ]
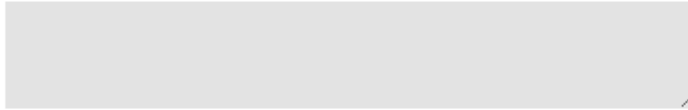
* 11. Please write up to five words that you associate with OCD.

[   ]

* 12. What do clients with OCD need from you as a clinician?

[   ]

* 13. Prior to watching the video how aware were you of the following:

	Not at all	A little	A moderate amount	A lot	A great deal
obsessional OCD (OCD symptoms that are thought based/not visible)?	○	○	○	○	○
harming/violent/aggressive obsessions as a common symptom of OCD?	○	○	○	○	○
sexual obsessions (e.g. pedophilia, incest, etc.) as a common symptom of OCD?	○	○	○	○	○
external or visible symptoms of OCD such as contamination/cleaning, symmetry/arranging items, etc?	○	○	○	○	○
mental rituals/compulsions as a symptoms of OCD? (i.e. rituals that cannot be observed externally)	○	○	○	○	○
guilt as a key feature of OCD?	○	○	○	○	○
experience of being a bad person as a key feature of OCD?	○	○	○	○	○

* 14. What symptoms were you least aware of?

* * *

* 15. Has the video improved your knowledge and understanding of OCD?

- ◯ Not at all
- ◯ A little
- ◯ A moderate amount
- ◯ A lot
- ◯ A great deal

* 16. Has the video improved your ability to accurately diagnose OCD?

- ◯ Not at all
- ◯ A little
- ◯ A moderate amount
- ◯ A lot
- ◯ A great deal

* 17. Please describe any reactions, comments, or thoughts you had to the video.

* * *

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Appendix C

Artwork From Workshops

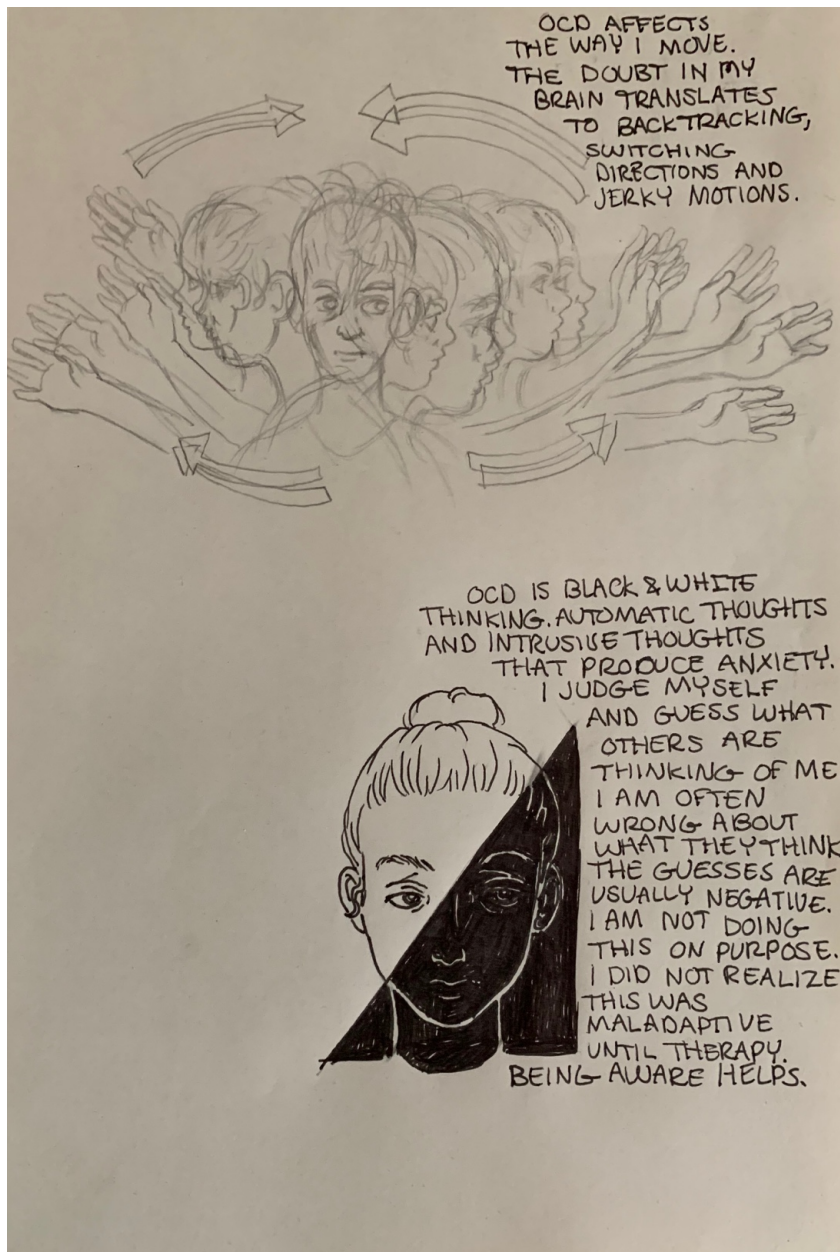**Figure C1**

Participant A's Artwork
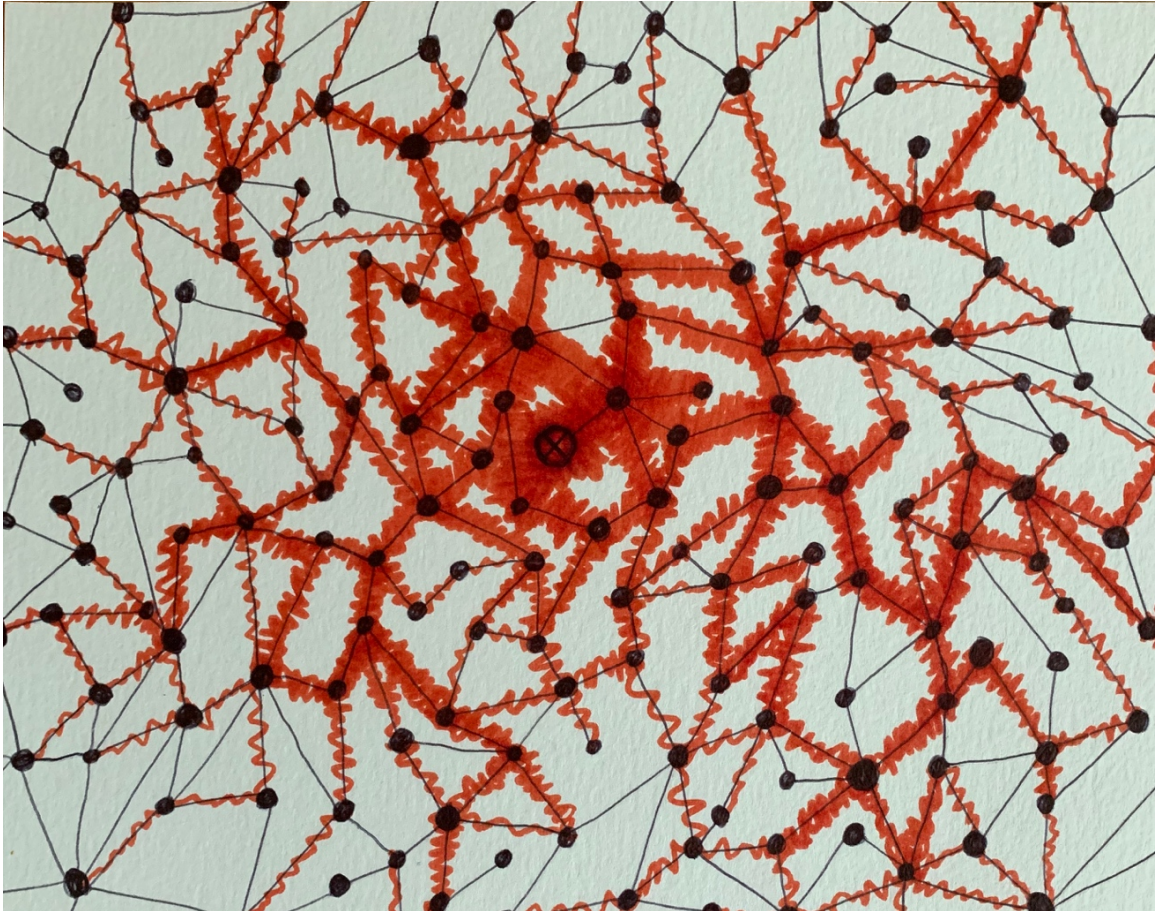
Figure C2

Participant B's Artwork

Figure C3

Participant C's Artwork

Figure C4

Participant D's Artwork

Figure C5

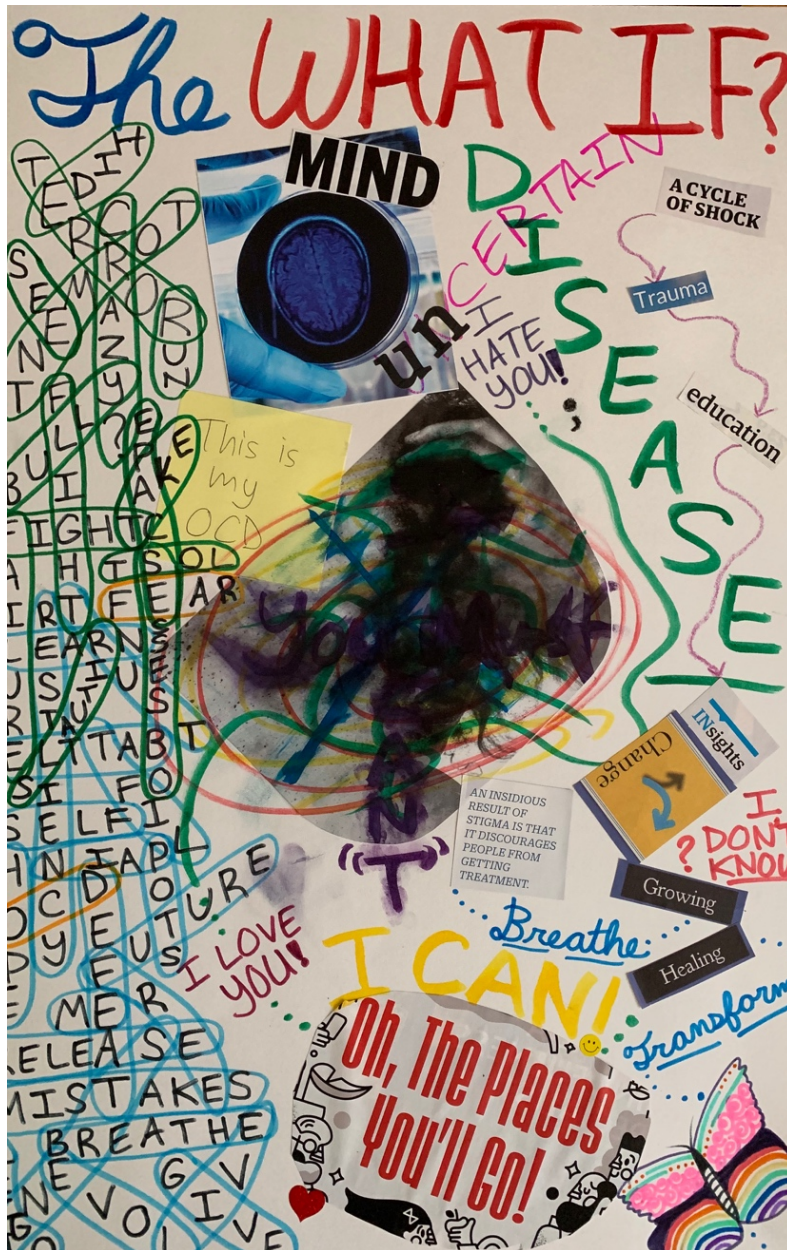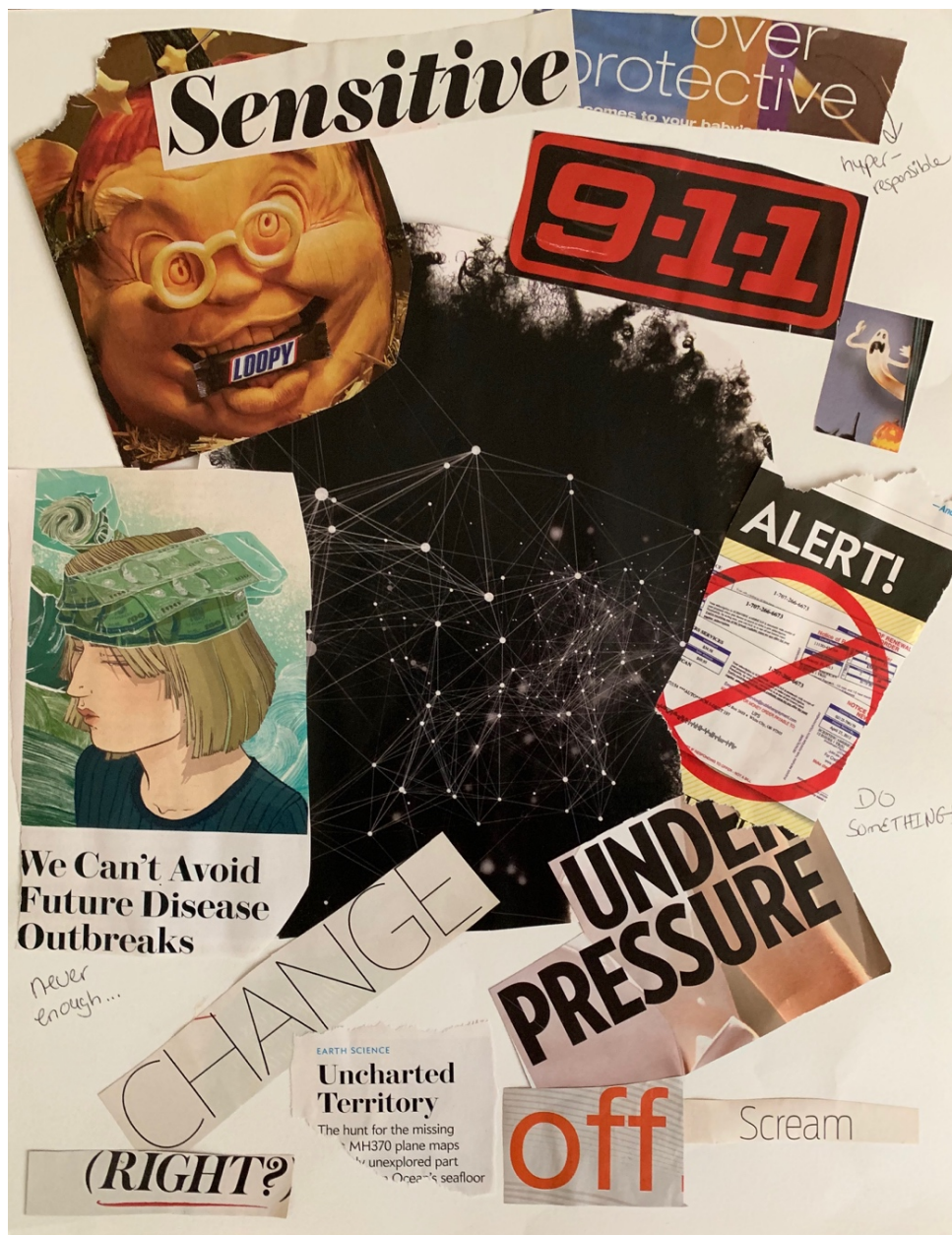*Participant E's Artwork*

Figure C6

Participant F's Artwork

Figure C7

Participant G's Artwork

Figure C8

Participant H's Artwork