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Professional and Student Understanding of Harm Obsessive–Compulsive Disorder: A Vignette Study

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Obsessive–compulsive disorder (OCD) is characterized by obsessions and compulsions that differ significantly across patients. Lesser known, harm-related obsessions (i.e., fears of harming others or oneself; harm OCD) can present in varying ways and are often misidentified—even by professionals—compared to more "prototypical" contamination obsessions. The present study surveyed a sample of professionals (registered psychologists, general practitioners; $n = 73$), doctoral psychology students ($n = 92$), and medical students ($n = 143$), gathering diagnostic impressions and risk judgements for one of several harm OCD vignettes (i.e., fears of harming one's infant, of smothering one's partner, of blurting an insult, or of completing suicide) as well as a contamination OCD vignette. Harm OCD (76%) was significantly less likely to be identified than contamination OCD (97%) through open-ended identification. Further, professionals and doctoral psychology students were significantly better able to identify harm OCD than MD students, and characters with harm OCD were perceived as more likely to harm others compared to those with contamination OCD. The current findings support the need for accurate media representation of the varying OCD presentations, as well as improvement in OCD medical education.

Public Significance Statement
Obsessive–compulsive disorder (OCD) is an often misunderstood psychiatric condition, with vastly different symptom presentations across individuals. The current research article highlights the difficulties that health professionals and trainees have in identifying less popularized presentations of OCD (i.e., harm OCD) that are highly prevalent but less represented in the media and educational materials compared to more "classical" presentations (i.e., Contamination OCD). Participants had more stigmatizing attitudes towards individuals with harm OCD (i.e., perceived dangerousness), which combined with greater rates of misidentification, represent significant barriers for treatment seeking.

Keywords: OCD, harm obsessions, clinical vignettes, symptom identification

Supplemental materials: https://doi.org/10.1037/cbs0000425.supp

Obsessive–compulsive disorder (OCD) is characterized by obsessions (i.e., intrusive, recurring thoughts causing distress), compulsions (i.e., repetitive behaviours mediating distress caused by obsessions), or both (American Psychiatric Association, 2013). While the lifetime prevalence of OCD worldwide is 1.3% (Fawcett et al., 2020), obsessive–compulsive symptoms are more prevalent in the community (8.3%; Adam et al., 2012), and experiencing intrusive thoughts is ubiquitous across nonclinical samples (93.6%; Radomsky et al., 2014). Impairments to the quality of life accompanying OCD have even been compared to schizophrenia (Subramaniam et al., 2013). OCD often goes untreated, given the up to 9-year lag between symptom onset and initiating treatment (Albert et al., 2019), increasing the likelihood of lifetime concurrent mental health conditions and contributing to poorer response to antidepressants (Albert et al., 2019; Pinto et al., 2006).

OCD presentations are heterogeneous, and symptoms often reflect important elements of the patient's life. These symptoms are often categorized into four distinct domains: (1) contamination (fears around germs/sickness, often accompanied by compulsive cleaning); (2) symmetry (a need for exactness/things to be "just right," often accompanied by compulsive repetition or meticulous arranging of objects); (3) responsibility for harm (obsessive self-doubt or false control over potentially harmful events, often accompanied by compulsive harm preventative actions including repetitive checking or avoidance behaviours); and (4) unacceptable thoughts (unwanted thoughts, images, or impulses that are violent, sexual, or blasphemous, often accompanied by compulsions to combat "bad thoughts" including reassurance seeking, praying, or avoidance behaviours; Abramowitz et al., 2010).

Harm OCD, or aggressive obsessions, do not fit neatly into one symptom dimension but encompass both the unacceptable thoughts and responsibility for harm domains (J. Abramowitz, personal communication, October 22, 2020). Aggressive obsessions may involve such fears as harming oneself or others (intentionally or accidentally), responsibility for something terrible (e.g., fire starting),

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harming others due to not being careful enough (e.g., vehicle accident), violent images, acting on unwanted impulses, blurting obscenities, stealing, or some other offensive behaviour (Glazier & McGinn, 2015; Goodman et al., 1989). Although aggressive obsessions have been found to be the most common obsessional theme in individuals diagnosed with OCD (61.9%; Hunt, 2020), contamination and symmetry themes are overrepresented in the media and educational materials (Bell, 2010; Fennell & Boyd, 2014; Lahey et al., 2024; Morrison, 2008). For instance, a recent Canadian medical school OCD curriculum review found that 70% of undergraduate medical textbooks provided no case example of OCD or solely offered contamination or symmetry examples (Lahey et al., 2024).

The lag between OCD onset and treatment may be perpetuated by low familiarity amongst health professionals for the lesser known symptom domains (Glazier et al., 2013). For instance, in a survey by Glazier, Swing, and McGinn (2015), physicians (those generally the first point of contact for mental health screening) were found to misidentify half of all OCD cases presented via vignettes (50.5%), with up to 80% misidentifying vignettes featuring aggressive obsessions (schizophrenia endorsed as the most common incorrect primary diagnosis). Similar results have been found for mental health professionals, with participants who viewed an unacceptable thought OCD vignette (depicting sexual, aggressive, or religious themes) being 99.7% more likely to misidentify the disorder than those who viewed a contamination OCD vignette (Glazier et al., 2013). Clinical psychology doctorate students again demonstrated significantly lower identification for noncontamination/nonsymmetry vignettes compared to the symmetry/contamination vignettes, with 36% of participants reporting being "not at all aware" or "not very aware" of aggressive obsessions (vs. 1.3% and 3.9% for contamination and symmetry obsessions, respectively; Glazier & McGinn, 2015). Thus, there appears to be a significant rift between symptom dimensions relative to their recognisability.

Proper identification of intrusive thoughts is critical as misidentification may result in improper diagnosis and contraindicated treatment approaches that exacerbate symptoms and prolong the lag between symptom onset and proper treatment. Evidenced in published case studies, individuals with aggressive obsessions have been misidentified as having psychosis and treated with antipsychotic medication that significantly exacerbated OCD symptoms and increased suicidal ideation (Boričević Maršanić et al., 2011; Leung & Palmer, 2016). In extreme cases, unnecessary involvement of law enforcement, social services, or involuntary psychiatric admission (Albert et al., 2019; Glazier, Swing, & McGinn, 2015; Vollers, 2020) can occur. Severe consequences can occur as a result of misidentification for patients—such as the cited case of a woman who lost custody of her children for 5 months following disclosure of intrusive, ego-dystonic thoughts of infant harm without intent (Vollers, 2020), despite the nearly universal prevalence of harming intrusions in the postpartum period (Brok et al., 2017). OCD can be commonly misdiagnosed as depression in the postpartum period given the lack of awareness of childbirth as a trigger for obsessive–compulsive symptoms and the overlap between depressive ruminations and obsessions (Grant, 2014; Singh et al., 2023). It is also not uncommon for severe cases of OCD to be mistaken for a psychotic disorder (Rohanachandra & Vipulanandan, 2019; Shad Mujeeb, 2017). Given that differential diagnosis and overconfidence have been shown to be the main contributing factors for diagnostic errors (Scott & Crock, 2020), greater awareness of the lesser known but prevalent OCD subtypes is required before OCD can even be in the running for differential diagnosis.

As an important rule of thumb, experiencing intrusive thoughts with OCD does not increase the likelihood of that fear coming to fruition (Collardeau et al., 2019). Mistaking unwanted, ego-dystonic obsessions for ego-syntonic motives to act falsely confirms a patient's greatest fear: that they are a danger (Glazier et al., 2013). As intrusive thoughts are distressing, going against the person's morals and sense of self, those with OCD are no more likely than the general population to act on their obsessions (Fairbrother et al., 2022; Veale et al., 2009). Despite this fact, stigmatizing attitudes have been disproportionately applied to harm OCD, with a recent systematic review finding that harm OCD was associated with higher public desire for social distance and higher perceived dangerousness of the vignette character compared to contamination/symmetry symptoms (Ponzini & Steinman, 2022). Relatedly, individuals with harm OCD and other more unusual symptom presentations (e.g., transformation obsessions or excessive fear of turning into another person/object or acquiring unwanted characteristics; Monzani et al., 2015) report feeling less comfortable disclosing their obsessions due to stigma and shame, fear of hospitalization, and fear of being misdiagnosed with a psychotic disorder (Glazier, Wetterneck, et al., 2015; Monzani et al., 2015).

The present study serves to expand on previous research, exploring identification rates across manifestations of harm OCD yet to be portrayed in a clinical vignette study (i.e., infant-related harm and suicidal OCD). Using contamination OCD and a non-OCD vignette (i.e., social anxiety) as comparisons, we are the first to explore OCD identification and stigma across several health professional (registered psychologists; general practitioners [GPs]) and student (Doctor of Medicine [MD]; clinical PhD; Doctor of Psychology [PsyD]) groups. We hypothesized that (1) participants would be less likely to correctly identify harm OCD than contamination OCD or social anxiety; (2) professionals (registered psychologists, GPs) would be better able to identify harm OCD, followed by doctoral psychology students (clinical PhD, PsyD) and MD students; (3) harm OCD vignette characters would be perceived as more likely to harm others than the contamination vignette character; and (4) due to findings that males tend to face a higher degree of perceived dangerousness than females in psychiatric contexts (i.e., Sowislo et al., 2017), we predicted that the male harm vignette character would be perceived as more likely to harm others and more likely to require imminent emergency services/referral as compared to the female character. Several exploratory analyses were also conducted to determine how identification differed across harm OCD vignettes, the most common differential diagnoses for harm OCD vignettes, and the relationship between correct identification and perceived dangerousness.

Method

Participants

This study was approved by the local Health Ethics Research Board, with data collection between July 2021 and February 2022. Samples of registered psychologists and GPs were recruited from across Canada and the United States by contacting respective provincial or state associations via email invitation. Of the 11 provincial or territorial psychological associations in Canada, 63.6% distributed our survey. For medical associations, 41.7% of Canadian ($n = 12$) and no U.S. associations ($n = 28$) confirmed distributing our survey. Canadian

students were recruited in a similar fashion by contacting programme administrators or advisors (power analyses presented below), with 35.3% of clinical psychology PhD programmes ($n = 17$), 50% of PsyD programmes ($n = 4$), and 37.5% of MD programmes confirming the distribution of our survey. The purpose of the study was portrayed as the identification of psychiatric conditions more generally. As compensation, participants were offered entrance into a raffle to win one of five $100 gift cards.

Materials and Procedure

This survey was conducted online using Qualtrics, and participants were discouraged from using outside resources. A total of 10 clinical vignettes were adapted from previously published research or clinical case studies (see Supplemental Table S1), including four harm OCD scenarios: fears of harming one's infant, harming one's partner, blurting out harmful insults, or completing suicide. Each harm OCD scenario had a female (Jean) and male (James) version, making a total of eight harm OCD vignettes. Critically, for each harm OCD vignette, the intrusive thoughts were described as causing the character significant distress, in an effort to delineate the ego-dystonic nature of the thoughts (although aggressive or repugnant thoughts can also cause distress as a result of concerns about what other people will think, going to jail, etc.). Two control vignettes were included: one depicting a more well-known presentation of OCD (contamination OCD) and one depicting a non-OCD condition (social anxiety disorder, Glazier & McGinn, 2015).

Following informed consent and a demographic questionnaire, participants were randomly assigned the first vignette (either one of the eight harm OCD experimental vignettes or the non-OCD/social anxiety control vignette), whereas the contamination OCD vignette was always the second vignette received across participants, as initial exposure to a popularized presentation of OCD was expected to cue participants to the nature of the study.

Following each vignette, participants gave their diagnostic impressions. First, participants answered an open-ended question wherein they listed and ranked up to three possible illnesses or conditions. Afterwards, they chose at least three diagnoses from a list of psychiatric and nonclinical conditions (e.g., distractor items such as "strong religious values"), ranking their choices numerically (updated from Glazier et al., 2013 to include *Diagnostic and Statistical Manual of Mental Disorders, fifth edition* diagnoses). Using a rating scale with corresponding scores ranging from 1 (*not at all likely*) to 100 (*extremely likely*), participants were asked to indicate how likely they believed the vignette character was to harm themselves, others, or require imminent emergency services.

Statistical Analysis

A priori power analyses were conducted using G*Power (Faul et al., 2009), determining the minimum sample size required for each analysis. In all cases, comparisons were adequately powered (i.e., statistical power of .80) based on the achieved sample size, except for the first hypothesis comparing identification of harm OCD, contamination OCD, and non-OCD (social anxiety), which was slightly underpowered only for the non-OCD comparison ($n = 35$ per group rather than the 36 required; $w = .30$, $\alpha = .05$, power = .80, $df = 2$).

Analyses were conducted using Jamovi, Version 2.2.5 (The Jamovi Project, 2022). Binary variables were analyzed using chi-square tests, and continuous variables were analyzed using *t* tests or analyses of variance, unless otherwise stated, with $\alpha = .05$. Identification was initially coded three ways: open-ended (one to three possible diagnoses of the vignette character was believed to have), top three ranked (as ranked from the list provided), and the most lenient criteria of whether OCD was listed at all in the ranked list (which was used by previous researchers; Glazier, Swing, & McGinn, 2015; Glazier & McGinn, 2015; Glazier et al., 2013). We have opted to prefer open-ended identification (unless stated otherwise). Importantly, all three coding schemes (open-ended, top three ranking, overall ranking) produce similar results, except when comparing harm OCD to non-OCD (see Supplemental Table S2).

Results

Sample Characteristics

A total of 353 participants completed the online study, with 44 excluded for only reporting demographics, and two excluded for taking less than 4 min to complete the survey (average duration in minutes, $M = 15.19$, $SD = 21.87$). See Table 1 for demographic information of the final sample of 308 participants.

Table 1
Demographic Characteristics of Entire Sample After Exclusions

Demographic characteristic	*N*	%
Gender		
Female	232	75.3
Male	72	23.3
Nonbinary	2	0.7
Prefer not to say	2	0.7
Race		
White	214	69.5
Asian	40	13.0
Other	15	4.9
Middle Eastern	11	3.6
Black	10	3.3
East Indian	8	2.6
Hispanic	2	0.6
Indigenous	2	0.6
Prefer not to say	6	1.9
Group (professionals)		
R.Psych	62	20.1
GP	11	3.6
Group (students)		
MD	143	46.4
Clinical PhD	72	23.4
PsyD	20	6.5
Country		
Canada	306	99.4
The United States	2	0.6
Professional training and experience characteristic	***M***	***SD***
Years practicing (professionals)		
R.Psych	13.98	10.21
GP	15.73	14.97
Current programme year (students)		
Clinical PhD	3.82	2.04
PsyD	2.30	1.17
MD	2.40	1.21

Note. $N = 308$. R.Psych = registered psychologists; GP = general practitioner.

OCD Identification Rates

Figure 1 outlines correct identification rates for each vignette condition (and Supplemental Table S3). Of the harm OCD vignettes, the male suicide vignette had the highest identification rate (88.9%), whereas the female perinatal vignette had the lowest identification rate (60.6%).

Hypothesis 1: Lower Identification for Harm Versus Contamination and Non-OCD

Identification results across vignette type and method of identification used are outlined in Supplemental Table S3. Excluding participants from the social anxiety condition, a McNemar test (Eliasziw & Donner, 1991) was used to evaluate OCD identification within subjects (harm OCD followed by contamination OCD vignettes), revealing participants to be significantly better at correctly identifying contamination OCD (97%) than harm OCD (76%). However, there was no significant difference between the harm OCD and non-OCD/social anxiety vignettes. Interestingly, this result changed when participants used ranked identification methods (top three or overall), wherein non-OCD identification was significantly superior to harm OCD identification (see Supplemental Table S2).

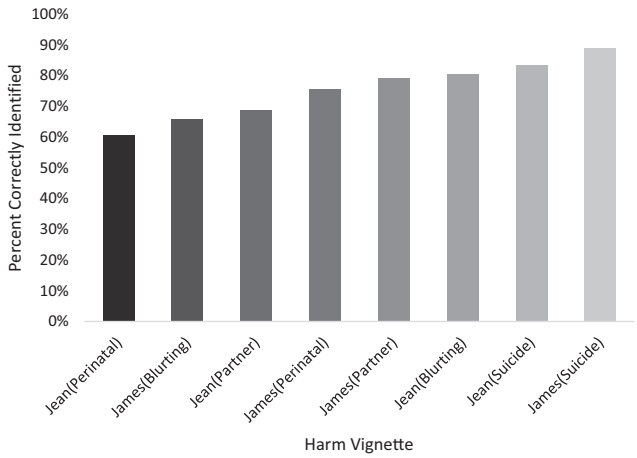
Hypothesis 2: Lowest Harm OCD Identification for MD Students

Harm OCD identification rates significantly differed by group (see Supplemental Table S3), $\chi^2(2, N = 272) = 22.83$, $p < .001$, Cramer's $V = .29$. Post hoc tests revealed that MD students showed significantly lower identification rates (62.4%) compared to professionals and psychology doctorate students combined (87.1%), $\chi^2(1, N = 272) = 22.38$, $p < .001$, Cramer's $V = .29$.

Exploratory analyses showed an overall disadvantage in harm OCD identification for medical (i.e., GPs and MD students) versus psychological training (i.e., psychologists, PhD psychology, and PsyD students; 62.5% vs. 89%, respectively), $\chi^2(1, n = 272) = 25.93$, $p < .001$, Cramer's $V = .31$.

Figure 1

Percent Correct Identification Rates by Specific Harm Vignette (Male and Female)



Hypothesis 3: Harm OCD Vignette Character as More Likely to Harm Others

Figure 2 outlines risk assessment scores. As predicted, harm OCD characters were deemed significantly more likely to harm others ($M = 27.25$, $SD = 24.04$) than the contamination character ($M = 8.47$, $SD = 12.16$), $t(258) = 13.84$, $p < .001$, $d = .86$, 95% CI [.71, 1.00].

Complementary to the preceding section, medical training was associated with significantly higher risk ratings for the harm OCD vignettes (32.8%) than psychological training (22.2%), $t(266) = 3.68$, $p < .001$, $d = .45$, 95% CI [.69, .20]. Additionally, medical students and GPs judged vignette characters to be at higher risk to harm themselves than psychology-based participants (42.4% vs. 34.5%), with similar results for the likelihood to involve police (14.8% vs. 7.6%), and likelihood to suggest Psychiatric Assessment Unit (PAU) admission (60.4% vs. 23.8%; $ps \leq .001$).

Exploratory analyses also found that the likelihood to harm others significantly varied across vignettes, $F(3, 264) = 25.15$, $p < .001$. Post hoc analysis revealed that the suicide vignette character was perceived as significantly less likely to harm others over the perinatal, $t(264) = 7.44$, $p < .001$; partner-focused, $t(264) = 7.39$, $p < .001$; and blurting insults characters, $t(264) = 4.01$, $p < .001$. Furthermore, characters in the perinatal, $t(264) = 3.38$, $p = .005$, and partner-focused vignettes, $t(264) = 3.49$, $p = .003$, were perceived as significantly more likely to harm others than the blurting insults character.

Hypothesis 4: Higher Risk Perception for Male Than Female Characters

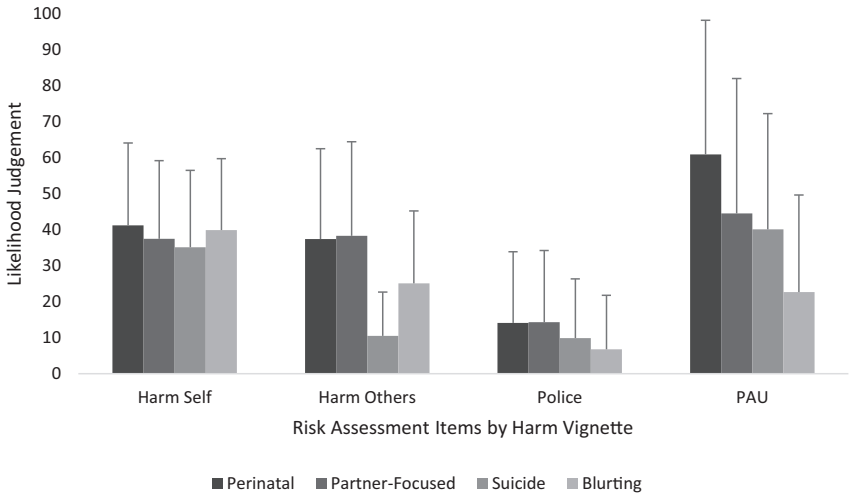
Contrary to our prediction, the harm OCD male character (James) was not perceived as more of a risk to harm others than the female character (Jean; see Figure 3), $t(266) = 1.46$, $p = .073$, $d = .18$, 95% CI [−.06, .42]. Similarly, neither police intervention, $t(266) = 1.38$, $p = .084$, $d = .17$, 95% CI [−.07, .41], nor likelihood to suggest psychiatric admission were impacted by character gender, $t(266) = .74$, $p = .231$, $d = .09$, 95% CI [−.15, .33]. However, for the suicide OCD vignette, James was perceived as significantly more likely to harm others than Jean, $t(68) = 2.21$, $p = .002$, $d = .53$, 95% CI [.04, 1.01]. There were no other significant differences found amongst the vignette types when evaluating propensity for risk or need for emergency services.

Most Common Misdiagnoses

Across all harm OCD vignettes, the most common misidentification was either generalized anxiety disorder or psychosis for open-ended identification (36.4%) and psychosis in participant top three rankings (42.4%). Even when participants correctly labelled the harm vignettes as being OCD, psychosis was also included in open-ended identification over a quarter of the time (26.5%). Specifically, the perinatal OCD vignette was most often misidentified as depicting symptoms of a psychotic disorder (e.g., postpartum psychosis; 71.4%), with the female perinatal OCD character ($n = 12$) mislabelled with psychosis 83.3% of the time. Perinatal depression was the second most common open-ended label for this vignette at 52.4%. This again was particularly prevalent when the perinatal vignette character was female

Figure 2

Risk Assessment Judgements (Risk to Harm Self, Risk to Harm Others, Need for Police Intervention, Need for PAU Referral) by Harm OCD Vignette

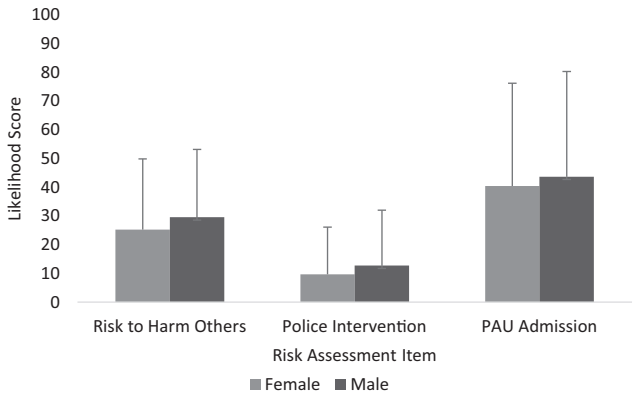


Note. Error bars represent standard deviations. Data from participants in the non-OCD condition are not relevant to this exploratory analysis and are therefore not represented in this figure. OCD = obsessive–compulsive disorder; PAU = Psychiatric Assessment Unit.

(83.3%). Similarly, the most common incorrect identification for the partner-focused harm OCD vignette was also psychosis (37.5%). Regarding the other harm OCD vignettes, the blurting insults vignette was most often misidentified as a motor/tic disorder (e.g., Tourette's syndrome; 63.2%), whereas the suicide OCD vignette was most commonly mislabelled as some type of depressive condition (i.e., major depressive disorder, depressive episode, etc.; 60.0%).

Figure 3

Risk Assessment Judgements for Harm OCD Vignettes by Type of Risk (Harm to Others, Police Intervention, PAU Referral) and Gender (Male, Female) of the Vignette Character



Note. Error bars represent the standard deviation for familiarity scores by dimension. This analysis concerned only risk assessment data from those participants who read a harm OCD vignette; and therefore, this figure does not include data for those who read the social anxiety vignette. OCD = obsessive–compulsive disorder; PAU = Psychiatric Assessment Unit.

Exploratory Analyses

We were also interested in examining whether correct identification of harm OCD resulted in destigmatizing attitudes. Likelihood of the vignette characters to harm others was rated as significantly lower in participants who correctly identified the vignette as representing OCD ($M = 23.19$, $SD = 21.63$) than those who did not ($M = 41.05$, $SD = 26.68$), $t(266) = 5.44$, $p < .001$, $d = .78$, 95% CI [.46, 1.09]. This pattern remained true for the perceived likelihood for the character to harm themselves, require police intervention, and admission into a PAU (all $ps < .008$).[1]

Discussion

Across health professionals and trainees primarily responsible for differentiating symptoms of psychiatric conditions, identification of harm OCD was significantly lower (76%) than contamination OCD (97%), with a heightened perception of risk of violence for the

[1] A series of further exploratory analyses were conducted to examine the impact that experience treating OCD had on identification rates. Across all participants, 45% had experience treating patients with OCD, ranging from 23% in medical students to 88% in registered psychologists. An independent-samples t test comparing those who identified harm OCD versus those who did not in relation to the total number of patients with OCD seen in the last 12 months was significant, $t(256) = -2.52$, $p = .012$, indicating that those who had correctly identified harm OCD had seen more OCD patients in the past 12 months ($M = 1.95$, $SD = 4.30$) than who had not ($M = 0.57$, $SD = 1.19$). Further, a chi-squared analysis comparing identification rates (yes, no) to experience treating OCD (yes, no) was also significant, $\chi^2(1, n = 257) = 6.93$, $p = .009$. For participants who had no experience treating OCD, 30.5% did not identify harm OCD, while 69.5% correctly identified harm OCD. For those who did have experience treating patients with OCD, a lower percentage (16.38%) did not identify OCD, and a higher percentage of participants (83.62%) did. Thus, the identification of harm OCD was enhanced as a result of recent treatment of patients with OCD. We would like to thank an anonymous reviewer for recommending these analyses.

former than the latter. Specifically, perinatal OCD was found to be the least recognizable presentation, along with significantly higher stigmatizing attitudes with respect to the risk to harm others and psychiatric hospitalization requirements. Furthermore, we determined that professionals and students with medical backgrounds, particularly MD students, were at a significant disadvantage in terms of OCD identification and risk perception as compared to those with psychology backgrounds.

Harm OCD Versus Contamination OCD: Implications for Medical Practice

The first hypothesis was mostly supported, with participants being significantly less able to identify harm OCD as compared to contamination OCD. While this finding may harken back to the fact that contamination (and symmetry) presentations of OCD tend to be the most well known and overrepresented in the media and educational materials (Bell, 2010; Fennell & Boyd, 2014; Lahey et al., 2024; Morrison, 2008), an alternate explanation is that aggressive obsessions (and other unacceptable thoughts) are commonly associated with avoidance and mental compulsions (Leonard & Riemann, 2012; Williams et al., 2011), which are less visible than more overt behavioural compulsions like handwashing in contamination OCD. For instance, the suicide OCD vignette, which included checking compulsions, was correctly identified at a higher rate than other vignettes that included reassurance seeking (blurting insults vignette) or avoidance-related compulsions (harming others/perinatal vignette), potentially making OCD symptoms less easily identifiable.

Supporting our second hypothesis, MD students were found to demonstrate significantly lower correct identification for harm OCD as compared to professionals and psychology doctorate students. Similarly, GPs and MD students showed significantly lower correct identification rates for harm OCD than the remaining psychology-based group (i.e., registered psychologists, doctoral psychology students). A recent review found that aggressive obsessions were the most commonly expressed category (61.9%) of obsessions in adulthood, followed by contamination (57.1%; Hunt, 2020). Yet, past and current research demonstrates that primary care providers are failing to identify Harm-related OCD symptoms with the same success as contamination-related symptoms.

Registered psychologists in the current sample were more accurate in identifying aggressive obsessions through ranked identification (86.5%) than Glazier et al.'s (2013) random sample of American Psychological Association members (68.5%). In contrasting to the two samples, most of the American Psychological Association members had a PhD in clinical psychology, whereas we did not distinguish between Canadian psychologists registered at the master's versus doctoral level. Whereas Glazier and colleagues did not assess experience treating OCD among participants, nearly 90% of registered psychologists in our sample had experience treating OCD. Thus, it is presently unclear whether differential educational or training experiences, regional differences, or other factors such as improved OCD awareness may have resulted in heightened identification rates for Canadian psychologists. Regarding doctoral psychology student performance, Glazier and McGinn's (2015) correct identification rate for aggressive obsessions (77.8%) is comparable to the present study's psychology student performance for harm obsessions (87.8%). The present study targeted clinical psychology students solely (i.e., current PhD clinical psychology students or PsyD students), whereas Glazier and McGinn (2015) recruited a broader sample of students in psychology, including clinical, counselling, and school psychology. Differences in the scope of practice, such as the emphasis on assessment and diagnosis in PhD and PsyD programmes, could potentially account for the higher identification rates of OCD found in this study. Additionally, the small sample of GPs in the present study showed improved ranked identification of harm OCD (45.5%) above the 20% found for aggressive obsessions in Glazier, Swing, and McGinn's (2015) GP sample. However, the pattern from past and present literature suggests that professionals and students in mental health fields show improved identification of Harm-related OCD symptoms than those in medical fields and that regardless of group occupation, contamination and/or symmetry OCD is identified most successfully.

Harm OCD Characters Perceived to Be at a Higher Risk to Harm Others

Previous literature supports that those with OCD are not at an increased risk to act on their obsessions anymore "… than a person with height phobia is to jump off of a tall building" (Veale et al., 2009, p. 333). Still, harm OCD vignette characters were perceived to be at increased risk to harm others compared to the contamination character. Of note, the three harm vignettes involving obsessions of perpetrating some form of harm against others (i.e., perinatal OCD, partner-focused, and blurting insults) were those that scored the highest in judgements about the risk to harm others—precisely what those with harm OCD often fear (Veale et al., 2009). Perceived dangerousness is often a measure of stigma, which, along with misidentification, is a major barrier to seeking treatment (McCarty et al., 2017). Thus, it is possible that the heightened risk perceptions for the harm OCD vignettes were a product of other possible diagnoses that participants were considering (e.g., postpartum psychosis, schizophrenia). Consistent with this notion, we replicated the stigma-reducing effect of correct OCD identification (McCarty et al., 2017), as harm likelihood judgements were significantly lower in those who correctly identified the vignette character as presenting OCD symptoms compared to those who did not. Still, it is notable that the risk to harm others was objectively prevalent even when OCD was correctly identified, especially when considering the high variability of the finding (i.e., $M = 23.19$, $SD = 21.63$). This indicates that those with OCD may be perceived as dangerous more generally.

The cognitive model of OCD emphasizes the disproportionate importance applied to unwanted thoughts, believing that even experiencing the thought indicates some intention to act (i.e., thought–action fusion; Obsessive Compulsive Cognitions Working Group, 2005). Thus, participants likely misinterpreted the intention behind obsessions, believing that the mere existence of violent thoughts increases the likelihood for aggression. If mistaking unwanted, ego-dystonic obsessions for ego-syntonic intentions, a physician may enact their right to warn a third party (see Smith v. Jones, 1999). Unnecessarily involving social services as a response to ego-dystonic thoughts of harm can have devastating impacts (Vollers, 2020) and falsely reinforce the importance of thoughts (Veale et al., 2009).

The underperformance of the present study's medical-based samples may be indicative of suboptimal OCD training in the

medical curriculum. Although psychiatrists and psychologists arguably receive more extensive training in psychiatric assessment and diagnosis, GPs are generally the first point of contact for individuals seeking treatment for OCD (Glazier, Swing, & McGinn, 2015; Lubian et al., 2016; Torres et al., 2007; Vuong et al., 2016). For instance, in England, the 2014 Adult Psychiatric Morbidity Survey found that while 65.4% of people with OCD discussed their mental health with a GP in that past year, less than a quarter (23.4%) reported receiving psychological therapy, and 18.5% reported having a consultation with a psychiatrist (Lubian et al., 2016). Thus, it is therefore critical to consider GP's knowledge and understanding of this condition. A recent Canadian medical school curriculum review (Lahey et al., 2024) found that one third of programmes did not discuss aggressive obsessions, and over half the medical programmes sampled did not discuss risk and ego-dystonic thought relative to OCD. Similarly, 70% of textbooks used in medical school in Canada either did not include a case example of OCD or focused examples on contamination/symmetry symptoms, 80% did not discuss lack of risk to harm, and 60% failed to differentiate between ego-syntonic and ego-dystonic thinking relative to OCD. Awareness and education of the varying presentations of OCD may help to avoid wrongful attribution of danger and the stigmatizing attitudes that follow, increasing the likelihood of self-disclosure for individuals experiencing harm OCD.

Gender Not a Significant Factor in Harm OCD Risk Assessment

Across all four harm vignettes, participants did not view the male vignette character, James, as being at a significantly greater risk to harm others nor require emergency intervention as compared to the female character, Jean. Therefore, participants in this study did not show significant gender-based prejudice relative to the propensity to act on violent impulses. Exploratory analysis, however, did discover that for the suicide vignette alone, James was perceived as significantly more likely to harm others than Jean. Given that the suicide OCD vignette was most commonly mistaken for some form of depressive disorder, perceived gender differences in the expression of depressive symptoms may have led to heightened harm perceptions for men. For instance, males with depression reportedly experience more frequent anger attacks and aggressive episodes than females with the condition (Martin et al., 2013) and experience more difficulty inhibiting reactions to strong, negative emotions (Brownhill et al., 2005).

Harm OCD Misidentified as Conditions With Disparate Symptoms

Psychotic disorders (e.g., schizophrenia, postpartum psychosis) were the most prevalent mistaken label across all harm vignettes and participant groups (48.7% overall ranking), replicating Glazier, Swing, and McGinn's (2015) finding that GPs most often mistook aggressive obsessions for schizophrenia (31.3%). Schizophrenia is considered in the top three most stigmatized mental illnesses, with common perceptions of unpredictability and high likelihood to harm others' judgements (Crisp et al., 2005, 2000). While psychotic disorders such as schizophrenia are associated with an increased likelihood to act aggressively (e.g., 23.7% for physical aggression; Li et al., 2020), OCD is not (Fairbrother et al., 2022; Veale et al., 2009). However, it is perhaps not surprising that the perinatal OCD vignette was most often misidentified as postpartum psychosis, given the potential symptom overlap (e.g., obsessive thoughts regarding the infant; Tinkelman et al., 2017).

With respect to differentiating the two conditions, harm-related thoughts in OCD are viewed as unreasonable and incompatible with one's beliefs and intentions (i.e., ego-dystonic) and met with marked anxiety and precautionary behaviour aimed at harm prevention, whereas psychotic episodes are characterized by poor insight, with delusional thoughts in postpartum psychosis generally viewed as being ego-syntonic (Fairbrother et al., 2022; Sharma & Sommerdyk, 2015; Tinkelman et al., 2017). In rare and more atypical cases of OCD with poor or nonexistent insight, delusional beliefs may develop, complicating the differentiation, although a clear link between the thoughts and rituals remains (O'Dwyer & Marks, 2000; Sharma & Sommerdyk, 2015). Although the nuance of distinguishing between these two conditions may have been challenging for participants given the limited nature of a clinical vignette, what is particularly concerning is the large number of participants who did not list OCD as a possible diagnosis to consider in this case, even when given a list of possible psychiatric diagnoses.

Participants who mistook postpartum harm OCD for postpartum psychosis may have been more risk-averse or conservative in their approach. Although the incidence of postpartum psychosis is relatively low (0.89–2.6 in 1,000 births according to a recent systematic review; VanderKruik et al., 2017), it constitutes a psychiatric emergency and can have dire consequences (e.g., suicide, infanticide) if left undetected and not properly treated (Doucet et al., 2011). Thus, it is important for clinicians to be aware of the risk factors for postpartum psychosis (e.g., primiparity; family history of bipolar disorder; history of psychosis; Doucet et al., 2011; Pfuhlmann et al., 2002; Sharma & Sommerdyk, 2015) and common symptom presentations. For instance, in a sample of 130 women admitted to a mother–baby inpatient unit with onset of psychotic and/or manic symptoms within the first 6 weeks of the postpartum period, irritability was the most frequent and hallmark symptom (73%), followed by abnormal thought content (72%), such as persecutory delusions, delusions of reference, and auditory hallucinations (Kamperman et al., 2017). The authors also identified a potentially underdetected profile of postpartum psychosis marked by depressive and anxiety symptoms, which further underscores the need for proper assessment of complex cases with sudden onset given the causal influence of childbirth in the development of postpartum psychosis (Kamperman et al., 2017).

Limitations and Future Directions

This was the first vignette-based study to compare OCD identification across professional and novel student samples (e.g., MD students) while incorporating harm OCD presentations previously unexamined in this literature (e.g., suicide OCD, perinatal OCD). However, we note several limitations, including difficulty in recruiting GPs (although physicians are notoriously difficult to engage in research and often have office policies prohibiting research participation; Tully et al., 2019; Wiebe et al., 2012) and the lack of participant diversity (e.g., predominantly White females). Additionally, the differential risk of being wrong about an OCD diagnosis (i.e., making a false positive diagnosis), when the intrusive thoughts are aggressive as opposed to involving contamination, is not equivalent and should not be downplayed. The majority of

clinicians, as a matter of best practice, may choose to err on the side of caution in an effort to ensure that the more obvious differential diagnoses (e.g., a psychotic condition or comorbid substance use) are adequately considered.

While participants in this study were not expected to provide a formal diagnosis from the case, but rather their general diagnostic impression at the outset, diagnostic identification was still based on vignette methodology, which is inherently limited in predictive and ecological validity. For instance, in terms of generalizability to real-world clinical settings, vignettes cannot adequately capture the iterative and interactive nature of real-world clinical interaction nor do they allow for the inclusion of relevant information from collateral sources or the possibility of collaborative input from other clinicians in an interprofessional setting. Further, while diagnostic ranking does provide insight into the range and types of differential diagnoses that the participants in the study might have been contemplating, in real-world interactions, the order and number of plausible differential diagnoses considered can change frequently and dynamically in response to the information that is elicited from the patient over an extended interview and evaluation.

Ideally, without time or financial barriers, criterion validity would be established for clinical vignettes by comparison to a standardized patient condition (Converse et al., 2015). While this was not feasible in the present study, the majority of vignettes were used in prior research and received expert input and review as recommended for ensuring content validity (Riley et al., 2021). More specifically, half of our vignettes were obtained from Glazier and McGinn (2015), who underwent a validation process for their vignettes, measuring interrater reliability across 32 mental health professionals for whether vignettes met their intended diagnostic criteria. The remainder of the vignettes utilized were previously published (e.g., Reavley & Jorm, 2011), based on published case studies for the novel vignette conditions (e.g., suicide OCD vignette, Al-Zaben, 2012; perinatal OCD vignette, Sharma & Sommerdyk, 2015; Hudak & Wisner, 2012) and reviewed by registered psychologists on the team. While the vignettes in the present study were succinct, the length of the included vignettes (between 90 and 107 words) was within the recommended length for vignette content in the field (50–500 words; Evans et al., 2015).

As a final limitation of the study design, the possibility of comorbidity was not accounted for despite the transdiagnostic nature of obsessions and compulsions, with obsessive thoughts and compulsive behaviours occurring across a wide range of disorders. For example, a recent meta-analysis of 94 studies found a 12% comorbidity rate between OCD and psychosis (e.g., schizophrenia spectrum disorder, first-episode psychosis), increasing to 24% when dimensional symptoms were also incorporated (e.g., OCD and psychotic symptoms as well as obsessive–compulsive symptoms and psychotic disorders; Mawn et al., 2020). Given the complexities of differentiating between and treating obsessive–compulsive and psychotic symptoms, with antipsychotic medication potentially inducing or exacerbating obsessive–compulsive symptoms in patients with psychosis (Leal et al., 2023), proficiency in differential diagnosis necessitates improved training in schizophrenia spectrum disorders and other presentations that are frequently confused for OCD.

Future research might benefit from enhancing written vignettes to incorporate audio or video clips (i.e., a video of a patient disclosing symptoms to a health care professional) to make the situation more realistic for clinical practice (Converse et al., 2015). Further, practicing psychiatrists (who receive 13–14 years of postsecondary education) and psychiatry residents may have been more appropriate comparison groups for psychologists and doctoral trainees, compared to GPs and medical residents. Additionally, future research may also benefit from including confidence ratings to accompany diagnostic impressions. Finally, vignettes depicting intrusive thoughts of harm against a stranger (rather than a partner, child, close friend, etc.) may have equated to changes in risk assessment.

Conclusion

Professionals and students were most familiar with popularized presentations of OCD (e.g., contamination OCD), while harm OCD had significantly lower identification rates, particularly perinatal OCD. Harm OCD vignettes were also associated with greater risk perceptions (i.e., likelihood to harm others) and were most often misidentified as either generalized anxiety disorder or psychosis. Those with medical versus psychological training were disadvantaged in identifying harm OCD. The current results call for a more accurate portrayal of OCD in media representation and educational materials, specifically regarding medical curriculum. More encompassing, representative examples of the major symptom domains are required, with an emphasis on distinguishing ego-dystonic and ego-syntonic thinking to enhance risk assessment. A comprehensive discussion of OCD in the classroom does not require a significant amount of time to achieve (Lahey et al., 2024) but could make a significant difference in the correct identification of OCD in practice. A better understanding of the vast heterogeneity in OCD symptomology and earlier identification should help in narrowing the substantial lag between the onset of symptoms and proper treatment.

Résumé

Les troubles obsessionnels compulsifs (TOC) se caractérisent par des obsessions et des compulsions qui diffèrent considérablement d'un patient à l'autre. Moins connues, les obsessions de blessure (c'est-à-dire la crainte de se blesser ou de blesser les autres; TOC de blessure) peuvent se présenter de différentes manières et sont souvent mal identifiées - même par les professionnels - par rapport aux obsessions de contamination plus « prototypiques ». La présente étude a porté sur un échantillon de professionnels (psychologues agréés, médecins généralistes; $n = 73$), d'étudiants au doctorat en psychologie ($n = 92$) et d'étudiants en médecine ($n = 143$), qui ont recueilli des impressions diagnostiques et des jugements de risque pour l'une de plusieurs vignettes de TOC de blessure (c'est-à-dire la peur de faire du mal à son enfant, d'étouffer son partenaire, de proférer une insulte ou de se suicider) ainsi que pour une vignette de TOC de contamination. Le TOC de blessure (76%) était nettement moins susceptible d'être identifié que le TOC de contamination (97%) par l'entremise d'une identification ouverte. En outre, les professionnels et les étudiants au doctorat en psychologie étaient nettement plus en mesure d'identifier le TOC de blessure que les étudiants en médecine, et les personnes souffrant de TOC de blessure étaient perçus comme plus susceptibles de faire du mal à autrui que ceux souffrant de TOC de contamination. Les résultats actuels confirment la nécessité d'une représentation médiatique

précise des différentes formes de TOC, ainsi que d'une amélioration de l'enseignement médical sur les TOC.

Mots-clés : TOC, obsessions de blessure, vignettes cliniques, identification des symptômes

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