HOW IS OBSESSIVE-COMPULSIVE DISORDER TAUGHT IN GRADUATE COUNSELING PROGRAMS?

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ABSTRACT

HOW IS OBSESSIVE-COMPULSIVE DISORDER TAUGHT IN GRADUATE COUNSELING PROGRAMS?

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The purpose of this study was to investigate how OCD is taught in graduate counseling programs. A quantitative approach with a qualitative element was used to explore the experiences of master's-level counseling students learning about OCD as well as to examine specific information taught about OCD in graduate counseling programs. Participants completed the OCD Counselor Education Questionnaire to assess how OCD was taught in their diagnosis coursework. Quantitative survey questions were analyzed using a frequency analysis, and qualitative answers were analyzed using thematic analysis. Findings revealed significant gaps in graduate counseling curriculum related to OCD symptomology, misdiagnosis, and evidence-based treatments, as well as an overall lack of education on OCD. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: obsessive-compulsive disorder, OCD, counselor education

Dedication

This dissertation is dedicated to my dad, Gerard “Peppy” Giroir, Jr.

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CHAPTER I: INTRODUCTION

This study addresses insufficient identification of obsessive-compulsive disorder (OCD) symptoms among mental health clinicians. Obsessive-compulsive disorder is a highly misunderstood, pervasive mental health problem (Storch, 2015) with a lifetime prevalence rate of 2.3% in the United States (Ruscio et al., 2010). While misdiagnoses exist across a variety of mental health concerns, the heterogeneity of OCD symptomology increases the potential for misdiagnosis in individuals suffering from the disorder. Researchers found that 38.9% of mental health professionals misidentified OCD, and the rate of misdiagnosis was significantly higher for symptoms not related to contamination (e.g., 77% for taboo OCD themes; Glazier et al., 2013). Further, increased early identification of OCD has the potential to decrease the severity of OCD symptoms, increase clinical outcomes, and prevent chronic development of the disorder (Fineberg et al., 2019). However, on average, individuals with OCD in the United States wait 10 to 17 years after first experiencing symptoms before receiving appropriate treatment (Marques et al., 2010; Pinto et al., 2006). This excessive latency period, as well as the rate of misdiagnosis, is likely related to scarcity of clinician education on the disorder (Senter et al., 2021), yet there is scant literature examining how OCD is taught in graduate counseling courses. Therefore, the current study has implications for counselor education programs. By identifying a potential educational gap in counseling graduate program curriculum, program directors can ensure students are better equipped to recognize OCD, meaning more clients who suffer from OCD will receive help.

Theoretical or Conceptual Framework

The researcher operated from a pragmatic framework in order to examine how OCD is taught in graduate counseling programs. In the researcher's practice as a clinician, she recognizes a need for more constructivist-based research in order to gain insights into lived experiences of individuals and to explore topics with greater depth. However, as a researcher, she also sees value in incorporating post-positivistic elements into the research process in order to expand on qualitative findings in a more generalizable manner. The researcher's work as a practitioner shapes her orientation toward a more pragmatic lens, viewing ontology in such a way that, depending on the research purpose, single or multiple realities may exist (Kaushik & Walsh, 2019).

Operating from a pragmatic paradigm, researchers select methodologies that are best suited to answer research questions, without strict adherence to qualitative or quantitative methods (Kaushik & Walsh, 2019). Pragmatists also aim to conduct research that addresses real-world problems in a practical manner, and one goal of pragmatic research is to decrease inequalities among humans (McWilliams, 2016). Therefore, the current study used a pragmatic design—quantitative in nature with a qualitative element—in order to address the problem of OCD misdiagnosis, with the ultimate goal of decreasing barriers for a misunderstood population. A pragmatic framework influenced this study, primarily in the chosen methodology. A quantitative approach with a qualitative element was selected because it allows for a comprehensive exploration of the topic, and the decision to combine quantitative and qualitative methods was informed by the research questions as well as by the researcher's axiology as a pragmatic researcher.

Statement of Purpose

The purpose of this quantitative study was to investigate how OCD is taught in graduate counseling programs. OCD misdiagnosis rates (Glazier et al., 2013) and latency periods (Albert et al., 2019) suggest that mental health professionals lack sufficient knowledge of the disorder; therefore, by examining individual student experiences in diagnostic courses, as well as the specific information about OCD that is taught across graduate counseling programs, a curriculum gap could be identified that indicates a need for more comprehensive education on OCD. To do this, current or former (i.e., graduated in the last two years) students in master's-level, CACREP-accredited counseling programs in the United States who have completed a synchronous master's-level counseling course in diagnosis were recruited to participate in a quantitative questionnaire with a qualitative element. Both quantitative and qualitative pieces centered around the participants' experiences as students learning about OCD in graduate programs.

Research Questions

ResQ1: What specific information about OCD is taught to graduate counseling students?

ResQ2: What are the experiences of graduate counseling students learning about OCD?

Significance of the Study

OCD is widely misdiagnosed (Glazier et al., 2013; Glazier et al., 2015; Perez et al., 2022) and misunderstood (Coles et al., 2013; McCarty et al., 2017), and there are significant delays between symptom onset and treatment for individuals with OCD (Albert et al., 2019; Pinto et al., 2006). In order to increase the identification of OCD and decrease the latency period between symptoms and treatment for OCD sufferers, Senter et al. (2021) suggested clinician education on the disorder. However, little is known about how OCD is taught in graduate-level counseling programs. This study has potential to identify gaps in graduate-level counseling curricula that

may contribute to the high rate of misdiagnosis of OCD among mental health professionals. This could have implications for counselor education programs, practitioners, and clients. If such an educational gap is identified and addressed by counselor education programs, OCD could be taught in a more comprehensive manner to counselors-in-training, meaning clinicians could be better trained in recognizing OCD, and clients could potentially receive evidence-based treatment sooner.

Definition of Terms and Operationalized Constructs

The following words and phrases are essential to this research study. Therefore, the definition of terms and constructs include the following. Compulsions are defined as excessive or ritualistic behaviors that individuals feel compelled to engage in as a way to neutralize distress caused by obsessions. These behaviors can include repetitive actions, physical rituals, or mental acts (American Psychiatric Association, 2022). Obsessions are defined as persistent, unwanted intrusive thoughts that cause distress. Specific content of obsessions varies greatly and can include obsessional content around contamination, aggressive behaviors, unwanted sexual thoughts, death, and perfectionism (American Psychiatric Association, 2022). Obsessive-compulsive disorder (OCD) is a pervasive, and, often debilitating, mental health concern that is characterized by the presence of obsessions and compulsions that are time-consuming and/or cause impairment in functioning (American Psychiatric Association, 2022). The latency period is the duration of time between symptom onset and diagnosis or symptom onset and treatment for individuals suffering from a mental health concern (Albert et al., 2019). Graduate counseling students are enrolled in master's-level counseling programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or recent graduates (i.e., within two years) of a CACREP-accredited graduate-level counseling program. In addition,

teaching refers to information presented or facilitated by an instructor during synchronous class time. This is to be differentiated from information presented through asynchronous materials, including textbooks.

CHAPTER II: LITERATURE REVIEW

This chapter provides a review of the current professional literature related to obsessive-compulsive disorder (OCD) and OCD misdiagnosis. The studies discussed in this chapter informed the proposed study's methodology and research questions. The primary databases used for the literature review were Antioch University Library and Google Scholar. The following search terms were used: obsessive-compulsive disorder misdiagnosis, OCD intrusive thoughts, OCD compulsions, OCD awareness and education, OCD heterogeneity, barriers to OCD treatment, obsessive-compulsive disorder training, OCD treatment gap, obsessive-compulsive disorder taboo themes, OCD misconceptions, counselor use of assessment instruments, obsessive-compulsive disorder mental health professionals, OCD stigma, and diagnosis of OCD. This literature review includes the following sections: obsessive-compulsive disorder overview, OCD latency period, barriers to OCD treatment, misconceptions of OCD, misdiagnosis of OCD, counselor education on OCD diagnosis, and impact of OCD education.

Review of Research Literature and Synthesis of the Research Findings

Obsessive-Compulsive Disorder Overview

Obsessive-compulsive disorder is a highly distressing mental illness with a lifetime prevalence rate of 2.3% and a 12-month prevalence rate of 1.6% in the United States (Ruscio et al., 2010). OCD is characterized by the presence of obsessions—which are unwanted, intrusive thoughts that cause distress—and compulsions, which are excessive or ritualistic behaviors aimed at neutralizing negative feelings that arise from obsessions (American Psychiatric Association, 2022). OCD is a highly misdiagnosed disorder (Glazier et al., 2013; Glazier et al., 2015; Perez, 2022), and the average latency period for individuals with OCD is 10 to 17 years from symptom onset to treatment (Albert et al., 2019; Pinto et al., 2006). Barriers to OCD

diagnosis and treatment have been explored in relation to client resources, client knowledge of the disorder, and access to care (Belloch et al., 2009; Goodwin et al., 2002; Vuong et al., 2016; Williams et al., 2012); however, clinician education has not been examined as a potential reason for high misdiagnosis rates.

Intrusive Thoughts

Intrusive thoughts are defined as "repetitive thoughts, images, or impulses that are unacceptable and/or unwanted" (Rachman, 1981, p. 89). Multiple studies have examined intrusive thoughts in clinical and non-clinical samples, finding differences in response to intrusive thoughts for the OCD population (Barrera & Norton, 2011; Belloch et al., 2004; Morillo et al., 2007; Rachman & Silva, 1978). In an early study, Rachman and Silva (1978) explored the differences between clinical obsessions and intrusive thoughts experienced by non-clinical samples. Results showed that non-clinical and clinical individuals experienced intrusive thoughts with similar content; however, participants with diagnosed clinical obsessions experienced these thoughts with greater frequency and increased levels of discomfort. Clinical participants also reported a significantly heightened desire to engage in behaviors that neutralize the distress caused by intrusive thoughts (i.e., compulsions) when compared to non-clinical participants (Rachman & Silva, 1978).

Building on Rachman and Silva's (1978) study, researchers compared intrusive thoughts in a sample of patients with OCD to the following three control groups: (a) patients with depression, (b) patients with anxiety not related to OCD, (c) and non-clinical community members (Morillo et al., 2007). In their study, frequency, content, impact, and response were specifically examined. Findings revealed that, while all groups experienced intrusive thoughts, participants with OCD reported an increased frequency of intrusive thoughts, heightened distress

associated with the thoughts, decreased control over the thoughts, and elevated avoidance of intrusive thought triggers. In addition, individuals with OCD experienced greater fear that the intrusive thoughts would come true when compared to the control groups (Morillo et al., 2007). These findings support prior research showing that individuals with OCD experience intrusive thoughts with increased frequency and distress in comparison to non-clinical individuals, and this study also introduced differences between patients with OCD and patients with other mental health concerns, such as depression and anxiety.

Similarly, findings from Barrera and Norton (2011) validated previous research that showed the relationship between the frequency of intrusive thoughts and OCD symptoms. However, results revealed that the intersection of frequency, distress, and responsibility was more indicative of OCD symptoms than frequency alone (Barrera & Norton, 2011). This supports a need for a multi-level appraisal of intrusive thoughts when diagnosing OCD to determine if the intrusive thoughts are clinical obsessions.

OCD Obsessions

As previously mentioned, the presence of intrusive thoughts alone does not indicate that an individual has OCD. OCD obsessions—as opposed to intrusive thoughts experienced by the non-clinical population—include elevated frequency of intrusive thoughts, significant distress associated with the thoughts, and behaviors used to avoid negative feelings stemming from intrusive thoughts (Barrera & Norton, 2011; Morillo et al., 2007). Obsessional content varies widely among individuals with OCD and can include intrusive thoughts in the following categories: harm, religion, contamination, aggression, morality, sex, perfectionism, and losing control (Clark & Radomsky, 2014; Hunt, 2020; Ruscio et al., 2010). However, most OCD sufferers often do not experience obsessions in a singular thematic content area, as results from

the National Comorbidity Survey Replication revealed that 81% of respondents reported OCD obsessions in multiple content realms (Ruscio et al., 2010). In order to meet the diagnostic criteria for OCD, obsessions must cause distress or anxiety, take up more than one hour per day, and cause impairment in functioning (American Psychiatric Association, 2022). As a result of OCD obsessions, individuals with OCD engage in compulsions.

OCD Compulsions

A compulsion refers to any physical behavior or mental act that reduces discomfort resulting from obsessive thoughts (American Psychiatric Association, 2022). Baer (1994) suggested the existence of a pure obsessional subtype of OCD, in which there are obsessions with no resulting compulsions, and this idea was promoted by other researchers as well (Pinto et al., 2007). However, in recent years, research has emerged debunking the notion of pure obsessional OCD as more awareness has been brought to the prevalence of mental compulsions. When mental rituals (i.e., reviewing events, counting, rumination, etc.) and reassurance seeking rituals were examined in cases of "pure obsessional" OCD, findings revealed that all participants exhibited obsessions and compulsions (Williams et al., 2011). In addition, Leonard and Riemann (2012) found that in a sample of 1,086 patients admitted to intensive outpatient or residential treatment facilities, both obsessions and compulsions were found in 100% of participants. It has been suggested that mental compulsions may be often overlooked by clinicians because of a lack of education on this type of OCD compulsion (Williams et al., 2011).

The most common OCD compulsions include checking, cleaning, mental rituals, repeating, reassurance seeking, and avoidance (Ruscio et al., 2010; Storch et al., 2010). In addition to the presence of distressing, time-consuming obsessions, diagnostic criteria for OCD also include repetitive behaviors or mental acts. These compulsions must be in response to an

obsession, and these behaviors are aimed at neutralizing anxiety or distress (American Psychiatric Association, 2022).

OCD Latency Period

Many studies have shown that there is a significant latency period between symptom onset and appropriate treatment for individuals with OCD (Albert et al., 2019; Cullen et al., 2008; Marques et al., 2010; Pinto et al., 2006; Stengler et al., 2013). Pinto et al. (2006) explored clinical features of OCD—including duration between symptom onset and treatment—finding that, in a sample of 293 American participants, the average time between first experiencing OCD symptoms and receiving OCD treatment was more than 17 years. A later study also investigated the mean latency period between the onset of OCD symptoms and OCD treatment; in a sample of 468 patients in the United States, the average duration between symptom onset and treatment was 12.8 years (Cullen et al., 2008). Similarly, Marques et al. (2010) examined treatment utilization in a sample of 175 individuals with OCD. On average, participants reported a 10-year latency period between OCD onset and treatment (Marques et al., 2010).

In addition to studies conducted in the United States, this latency period has been explored in European samples, yielding similar results. Albert et al. (2019) retroactively analyzed patient records to determine the duration of untreated illness (DUI)—or the duration between symptom onset and treatment—in a sample of 251 Italian patients with OCD, and findings revealed a mean DUI of 9.3 years. Further, a German study examined help seeking behaviors in 88 individuals with OCD through an online survey (Stengler et al., 2013). Findings revealed that the mean latency period between onset of symptoms and first professional help was 8 years; however, the average time from symptom onset to receiving an OCD diagnosis was 10.8

years. This suggests that inaccurate diagnosis may play a role in this latency period, which could serve as a barrier to treatment.

Barriers to OCD Treatment

There is a growing body of literature examining specific barriers to OCD treatment, which could help explain the significant latency period between symptom onset and treatment for individuals with OCD. Goodwin et al. (2002) investigated predictors of help-seeking behaviors in a sample of Americans with OCD. Approximately 40% of participants reported a lack of knowledge regarding where to seek help as the primary reason they had not sought out treatment. Further, individuals who had received treatment for OCD were older and Caucasian, suggesting that age and race play a role in access to treatment (Goodwin et al., 2002). Additionally, a qualitative study exploring help-seeking behaviors in a sample of 26 individuals with OCD found that the most commonly reported reasons for delaying treatment-seeking were stigma and lack of knowledge about OCD, supporting the notion that more educational efforts on OCD symptomology could reduce barriers to treatment for this population (Belloch et al., 2009). Gentle et al. (2014) also examined barriers to treatment in a sample of 86 Australian individuals with OCD, and participants reported the following barriers to receiving treatment: preference for handling problems on their own (43%), embarrassment (37%), and lack of knowledge (12%).

Specifically examining barriers to OCD treatment among African Americans, Williams et al. (2012) found that African American participants experienced some similar barriers as European Americans, such as stigma and shame. However, African Americans were more likely to have less knowledge regarding where to seek help and reported more concerns related to discrimination than European Americans in the study (Williams et al., 2012). In addition to stigma and lack of client knowledge, Vuong et al. (2016) found that lack of awareness of OCD

by healthcare professionals was reported as a primary barrier to treatment for individuals with OCD. Further, the largest proportion of participants in this study reported identifying their OCD through internet searching and not through a provider (Vuong et al., 2016). Across the aforementioned studies, stigma and lack of knowledge appear to be the most commonly reported barriers to OCD treatment, which may be due to misconceptions of OCD among both the lay population and among clinicians.

Misconceptions of OCD

OCD is often misunderstood by the general public. Coles et al. (2013) investigated the public's knowledge of OCD by conducting telephone interviews with 577 adults living in the United States; participants were given a case vignette describing an individual with OCD symptoms, and, while 90% of participants identified that the issues were concerning and warranted seeking professional help, only 33% were able to identify the concern as OCD. Further, 14.7% of participants thought that the person in the vignette should not share their symptoms due to potential stigma. Coles et al. (2013) noted that the case vignette portrayed stereotypical OCD symptoms (i.e., obsessions and compulsions around germs and illness) and suggested that the identification rate may be lower for other, lesser-known OCD themes. Stewart et al. (2019) also utilized telephone interviews to examine recognition and perceptions of OCD among 806 adult residents of New York. While the majority of respondents indicated they had heard of OCD, most participants described OCD in terms of perfectionism or repetitive behaviors. Moreover, participants who had not heard of OCD were more likely to be ethnic minorities, less educated, and of lower socioeconomic status (Stewart et al., 2019). Findings suggest that the public has limited views of OCD (i.e., solely perfectionism or repetitive behaviors) and that individuals from specific backgrounds may have less knowledge of OCD.

Stigma

Misconceptions of OCD also contribute to public stigma related to certain subtypes of the disorder. For example, a sample of 113 undergraduate students were given three vignettes, each focusing on a different OCD subtype (harm, washing, or checking), and participants were then asked to evaluate the individual in the vignette based on fear, shame, and social acceptance (Simonds & Thorpe, 2003). Harm obsessions and compulsions were rated significantly higher on measurements of fear, shame, and social rejection when compared to washing and checking symptoms. Participants indicated they believed the individual in the harm OCD vignette should be afraid of disclosing their symptoms to others. This suggests that the perception of specific OCD subtypes may impact stigma as well as the willingness of individuals to disclose symptoms (Simonds & Thorpe, 2003). Similarly, in a study by McCarty et al. (2017), a sample of 738 adults in the United States was assigned to one of five different OCD case vignettes and then given questionnaires assessing their reactions to the vignettes. The vignettes describing an individual with obsessions and compulsions related to contamination and symmetry were more readily identified as OCD by participants (76.1% to 84.5%), while vignettes describing OCD symptoms related to harm or taboo (e.g., perverse sexual behaviors) content areas were not as easily recognized (30.9% to 36.9%). Further, participants who received a case vignette with OCD symptoms around taboo content reported significantly higher levels of stigma towards the individual in the vignette. McCarty et al. (2017) suggested that increased stigma related to taboo obsessions may be due to a lack of public awareness of different presentations of OCD.

Misdiagnosis of OCD

Misconceptions of OCD are not limited to the general public, and healthcare practitioners also often have limited knowledge of OCD. Glazier et al. (2013) examined mental health

professionals' awareness of OCD symptom presentation. Three hundred sixty members of the American Psychological Association received one of five OCD case vignettes, and they were asked to provide their diagnostic impressions. Thirty-eight point nine percent of participants misidentified OCD across all case vignettes; however, misdiagnosis rates were significantly higher for OCD vignettes representing taboo OCD content areas when compared to contamination vignettes (i.e., 15.8% misidentification rate for the contamination vignette versus 42.9% to 77% misidentification for taboo vignettes). Sexual obsessions, in particular, were misidentified by providers (Glazier et al., 2013). This finding is especially notable given that a study examining the prevalence of taboo sexual obsessions in OCD patients found that 24.7% of participants endorsed a history of sexual obsessions (Grant et al., 2006), meaning these intrusive thoughts are commonly occurring in individuals with OCD.

Similar results were found in a study investigating OCD symptom awareness among clinicians in Latin America (Perez et al., 2022). One hundred twelve Latin American mental health professionals were provided with OCD and non-OCD case vignettes and were asked to offer a diagnosis as well as their treatment recommendations. Supporting results from the Glazier et al. (2013) study, misidentification rates were higher for taboo vignettes (42% to 52.7%) in comparison to contamination vignettes (11%). OCD symptoms around sexual obsessions were most commonly misdiagnosed as paraphilic disorders (36.5%). Further, exposure and response prevention—the gold standard treatment for OCD (Kircanski & Peris, 2015)—was scarcely mentioned in participant treatment recommendations (Perez et al., 2022). These research findings suggest a lack of knowledge of OCD symptoms among mental health professionals, which could lead to the misdiagnosis of clients.

Specifically looking at OCD symptom awareness among physicians, Glazier et al. (2015) surveyed primary care doctors in the greater New York area using case vignettes. Participants randomly received one of eight OCD vignettes and were asked to give a diagnosis. The overall misidentification rate was 50.5%, and misdiagnosis rates for aggressive and taboo content vignettes ranged from 70.8% to 84.6% (Glazier et al., 2015). In addition, Wahl et al. (2010) examined psychiatrist recognition rates of OCD within 14 German outpatient clinics. Existing patients who agreed to participate in the study were given OCD screening questionnaires, and participants who met the threshold for an OCD diagnosis were then interviewed by the researchers. Of the 69 patients who met criteria for OCD and completed the subsequent interview confirming the diagnosis, only 27.5% of patients had previously received an OCD diagnosis from their practitioner. This means that over 70% of patients presenting with significant OCD symptoms had been misdiagnosed by their doctors (Wahl et al., 2010). These studies further suggest a need for OCD education for healthcare professionals.

Additionally, researchers utilized a scoping review method to examine the gap in diagnosis and treatment of OCD, searching electronic databases from 2000 to 2020 (Senter et al., 2021). In their review, they found a significant theme of underdetection of OCD, primarily due to a lack of knowledge of OCD symptoms and treatment, clinician misdiagnosis, and underuse of evidence-based treatment when OCD is identified. Senter et al. (2021) recommended the following avenues for addressing the gap: (a) patient and family education, (b) clinician education, (c) use of OCD screening assessments in healthcare settings, and (d) increased use of evidence-based treatments for OCD. These practices have the potential to decrease OCD misdiagnosis rates and increase overall mental health literacy around OCD.

Counselor Education on OCD Diagnosis

The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) provides standards for graduate counseling programs and specifically addresses the topic of counselor education related to diagnosis. Clinical mental health counseling programs adhering to CACREP (2016) standards must provide education to students on case conceptualization (2.F.5.g.), the process of diagnosing clients (5.C.2.d.), and diagnostic assessment (5.C.3.a.). These educational standards are especially important because incorrect diagnosis can lead to ineffective, or even harmful, treatment practices (McKay et al., 2021). However, little is known about how the diagnosis of OCD, specifically, is addressed in counseling graduate programs.

Neukrug et al. (2013) investigated which assessment instruments were most commonly covered in master's-level counseling courses in testing and assessment, and 210 counselor educators responded to a survey, reporting which instruments they included in their teaching. Of the 174 inventories included in the survey, no OCD inventories were mentioned (Neukrug et al., 2013). While this means the prevalence of the inclusion of OCD instruments in counseling assessment courses remains unknown, the questionnaire was developed through examination of four textbooks prominently utilized by counselor educators, suggesting that OCD assessment instruments are not widely taught.

Impact of OCD Education

While there is scarce literature exploring how OCD diagnosis is taught in graduate counseling programs, some studies have examined the efficacy of proper OCD education. In a study by Glazier and McGinn (2015), a sample of 82 psychology doctoral students reviewed five OCD case vignettes and were asked to provide their diagnostic impressions prior to watching an

educational video on OCD. Aligning with prior studies, participants indicated significantly less awareness of OCD symptoms that were not related to contamination or symmetry, and they were also more likely to misdiagnose vignettes with OCD subtypes outside of these two areas. However, after the video intervention, misidentification rates dropped significantly for all OCD subtypes (Glazier & McGinn, 2015).

Education on OCD symptoms also has the potential to reduce stigma associated with the disorder. Gürbüz et al. (2020) investigated the impact of an anti-stigma intervention program for OCD; participants who received the intervention—which was an anti-stigma OCD video—reported significantly fewer negative beliefs related to OCD case vignettes from pre-test to post-test. This suggests that education on OCD has the potential to reduce stigma and increase understanding of the disorder. Snethen and Warman (2018) more specifically examined the impact of OCD education on perceptions of pedophilic sexual OCD obsessions. Ninety-four university students were given an OCD vignette reflecting an individual with pedophilic intrusive thoughts, and students were randomly assigned to receive this vignette with one of the following diagnostic labels: OCD, pedophilic disorder, or no diagnosis. Participants were asked to provide their own diagnosis as well as their attitudes towards the individual. Participants were then provided educational materials on OCD symptom presentation and diagnostic criteria for OCD and pedophilic disorder. After reviewing the educational content, participants were asked to re-read the vignette and offer their evaluations again. The majority of participants (79%) changed their diagnosis from pedophilic disorder to OCD, and negative attitudes towards the individual in the vignette significantly decreased. Specifically, participants reported significantly lower levels of perceived dangerousness and less desire for social distance after the educational content. Further, prior to the OCD education, 65% of participants who received the vignette with

an OCD diagnostic label rejected the provided diagnosis, while only 20% of participants who received the vignette with a pedophilia diagnostic label disagreed with the given diagnosis. Findings from this study suggest that public knowledge of pedophilic OCD is minimal, and that brief education on OCD can significantly increase awareness of OCD symptoms and decrease the perceived dangerousness of someone with pedophilic OCD intrusive thoughts (Snethen & Warman, 2018).

Further, Warman et al. (2015) explored perceptions of violent OCD intrusive thoughts in a sample of college students. Participants were given one of three possible vignettes representing each of the following diagnoses: OCD, schizophrenia, or no diagnosis. Participants gave a diagnostic label and then rated how dangerous or unpredictable they found the individual in the vignette. After receiving a short educational intervention on OCD and schizophrenia, participants completed their evaluations again. Findings revealed that negative attitudes towards the individual in the vignette decreased significantly after the intervention, and correct identification of OCD increased (Warman et al., 2015). These studies highlight the impact of OCD education on reducing stigma and increasing identification of the disorder.

Rationale

The studies included in this literature review informed the current study. Researchers have identified that OCD is misidentified by the general public (Coles et al., 2013; Stewart et al., 2019) as well as by mental health professionals (Glazier et al., 2013; Perez et al., 2022) and medical doctors (Glazier et al., 2015; Wahl et al., 2010). Researchers have also found that individuals with OCD are highly stigmatized, particularly in relation to sexual and aggressive obsessions (McCarty et al., 2017; Simonds & Thorpe, 2003). Obsessions and compulsions related to sexual and aggressive content are also the least likely to be properly identified as OCD

by both healthcare professionals (Glazier et al., 2013; Perez et al., 2022) and the general public (Snethen & Warman, 2018). This suggests that increased education on OCD, specifically related to taboo content areas, can significantly increase the identification of OCD and decrease stigma associated with the disorder. Further, research findings supporting the efficacy of OCD educational efforts in increasing knowledge of OCD symptoms and reducing stigma associated with the symptoms (Gürbüz et al., 2020; Warman et al., 2015) reinforce the potential benefits of proper education on OCD.

Studies have shown that a lack of clinician knowledge of OCD is a significant barrier to diagnosis and treatment for individuals with OCD (Senter et al., 2021; Vuong et al., 2016); however, little is known regarding how OCD is taught to mental health professionals in training programs. Therefore, the current study sought to understand student experiences learning about OCD in graduate counseling programs as well as to identify the content taught around OCD in their programs. Based on the literature reviewed in this chapter, it is probable that counselors-in-training are not being taught about OCD in a comprehensive manner that aids identification of the disorder outside of contamination and symmetry symptoms. If this gap in education is identified, efforts could be made by graduate counseling programs to improve OCD diagnostic curriculum.

CHAPTER III: METHOD

Aligning with a pragmatic paradigm, this study used a quantitative design with a qualitative element to best answer the research questions. This study addressed the following research questions using a predominantly quantitative design: (1) What specific information about OCD is taught to graduate counseling students? and (2) What are the experiences of graduate counseling students learning about OCD?

Study Design

By utilizing a quantitative approach with a qualitative element, the research questions were answered in a way that provided both breadth and depth of understanding. The question, 'What specific information about OCD is taught to graduate counseling students?' was answered through quantitative items on the OCD Counselor Education Questionnaire. The question, 'What are the experiences of graduate counseling students learning about OCD?' was examined through a qualitative question at the end of the survey. Thus, findings provided insight into data that is generalizable to a larger population as well as into individual experiences.

Study Context

Data was collected through Qualtrics, an online data collection platform. Utilizing anonymous online surveys reduces risk due to the confidential nature of the method. Therefore, this data collection method was chosen to keep participant data anonymous as well as to increase researcher accessibility to a larger sample.

Participants

This study included a sample of 150 participants, which aligns with prior studies utilizing a sample of graduate counseling students in CACREP-accredited programs (Mullen et al., 2015; Person et al., 2020; Perusse et al., 2015). Participants were recruited by contacting counselor

education program directors via email as well as through recruitment advertisements on CESNET, a listserv for counselors, counselor educators, and supervisors. Individuals were considered eligible if they met the following inclusion criteria: (a) current or recent (graduated in the last two years) student in a CACREP-accredited clinical mental health counseling program and (b) completion of a synchronous master's-level counseling course in psychopathology, diagnosis, or other equivalent class meeting CACREP standards for diagnosis coursework. Individuals were excluded from participating if they attend(ed) Antioch University Seattle (AUS). At the time of recruitment, the principal investigator instructed the psychopathology course at AUS, which may have skewed data if students from this university participated. Participants had the option to be entered into a drawing to receive an $80 Amazon gift card as compensation for their participation.

Data Sources

Sociodemographic Questionnaire

The sociodemographic questionnaire designed for this study included six forced-choice questions and collected participant characteristics in the following domains: age, gender, race, ethnicity, and time enrolled in graduate program or time since graduation (see Appendix B).

The OCD Counselor Education Questionnaire

The OCD Counselor Education Questionnaire (OCEQ; Smestad, 2023) was designed specifically for the purposes of this study. The OCEQ is a 12-item self-report survey measuring how OCD is taught in graduate counseling programs (See Appendix C). This instrument includes questions related to specific information on OCD education in master's level counseling diagnosis courses, including time devoted to OCD, OCD thematic content, and presented treatment modalities. The survey also includes questions related to student perceptions of

preparedness. A qualitative question was included at the end of the OCEQ in order to gain better insight into individual experiences (See Appendix C).

A mixed methods study approved by Antioch University Seattle's Institutional Review Board was conducted to assess for validity and reliability of this instrument. Participants were recruited by contacting students and faculty members at Antioch University Seattle via email. Participants were considered eligible if they met the following inclusion criteria: (a) status as a current student or faculty member in the clinical mental health counseling or counselor education and supervision program at Antioch University Seattle and (b) completion of a master's-level counseling course in psychopathology, diagnosis, or other equivalent class meeting CACREP standards for diagnosis coursework.

A focus group consisting of master's (n = 4) and doctoral (n = 3) students was conducted in order to achieve increased understanding of the following: (a) perceptions of the questions on the OCEQ, (b) the degree to which the instrument appeared to measure the intended construct, and (c) how the instrument could be improved. All seven participants reported high face validity for each question on the OCEQ. The principal investigator utilized feedback from focus group participants to revise the questionnaire prior to assessing for reliability. Specifically, the following adjustments were made: The term "psychopathology/diagnosis course," which was utilized throughout the survey, was changed to "core diagnosis course(s)" in order to increase understanding of the questions and to emphasize the inclusion of all core diagnostic classes in a participant's graduate program. Additionally, an option of "student presentation" was added to the question, "Who presented the information on OCD in your core diagnosis course(s)?" in order to include another possible teaching modality in the answer choices. Finally, the qualifier, "specifically related to OCD content" was added to the end of the question, "Which of the

following subtypes of OCD obsessions and compulsions were explicitly mentioned in your program's core diagnosis course(s)" in order to offer further clarification of the question's intent. A member check—in which the principal investigator emailed all participants with the updated questionnaire as well as details regarding the changes made—was conducted to ensure the revised questionnaire accurately reflected feedback from the focus group. Participants confirmed that the revisions matched the conclusions from the focus group.

In order to measure the instrument's test-retest reliability, 72 participants completed the OCEQ at two points in time, once at the start of the quantitative phase and once 15 days later. There was a 94.4% response rate. Four participants completed the initial questionnaire but did not complete the OCEQ a second time; therefore, their responses were not included in data analysis. Participant answers between the two survey attempts were compared, and a Pearson product-moment correlation coefficient was calculated using JASP, a free, open-source statistical analysis software similar to SPSS. The correlation coefficient between test and retest demonstrated good reliability ($r = 0.88$). Portney and Watkins (2015) proposed the following scale for assessing the test-retest reliability of instruments in clinical fields: A correlation coefficient of 0.5–0.75 is considered poor to moderate; a correlation coefficient of 0.75–0.9 is considered good, and a correlation coefficient exceeding 0.9 is considered excellent. Therefore, the correlation coefficient for the OCEQ test-retest reliability study ($r = 0.88$) indicated good test-retest reliability, justifying its use in the current study. Further data analysis will be conducted to assess reliability of the instrument by examining individual participant responses. Additionally, each question will be assessed in future data analysis to better understand the reliability of specific questionnaire items.

Data Collection

Institutional Review Board approval and informed consent were obtained prior to the start of data collection. Participants were provided with a link to the informed consent form and study questionnaires. Consent was obtained prior to starting the questionnaire. Consent was given when participants proceeded to the sociodemographic questionnaire and the OCD Counselor Education Questionnaire.

Data Analysis

Quantitative survey data were analyzed using JASP, a free, open-source statistical analysis software similar to SPSS. Data were cleaned for missing scores, meaning responses from participants who did not fully complete the survey were removed prior to data analysis. Demographic constructs were transformed into numerical values using JASP's export feature. Quantitative data analysis included descriptive statistics and frequency analysis. Data from the qualitative survey question was analyzed using thematic analysis, meaning data was categorized into themes until the phenomena were merged, which is an analysis method commonly used in mixed methods research (Clarke & Braun, 2017), and this approach promotes data collection through open-ended survey questions (Terry & Hayfield, 2021). According to Braun and Clarke (2006), the thematic analysis process includes the following six phases: (a) familiarizing oneself with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing potential themes, (e) defining and naming themes, and (f) producing the report. This was the process that was followed for the analysis of qualitative data in the current study. Thematic analysis is considered a flexible process in which researchers identify themes based on patterns; therefore, details such as number of participants who reported specific themes or the presence of contradictory statements are not identified when using this method (Terry & Hayfield, 2021).

Throughout the qualitative analysis process, the researcher engaged in reflexive practices and discussed experiences with a research mentor to check for possible biases and to increase trustworthiness of data. Qualitative and quantitative data were analyzed separately. Qualitative data was then triangulated by cross-checking findings with quantitative results.

Assumptions and Limitations

Based on the current literature, as well as the researcher's clinical practice, the following assumptions were made: (a) The majority of quantitative survey participants would indicate their diagnostic course did not discuss sexual and aggressive OCD content areas. (b) The majority of quantitative survey participants would report that OCD received less attention in their diagnostic course when compared to other mental illnesses. (c) Exposure and response prevention would not be the most frequently reported evidence-based treatment for OCD taught to participants, and (d) responses to the qualitative question would reveal limited education on OCD in diagnostic classes. These assumptions are relevant to the field of counseling because this information could reveal a gap in the counseling graduate program curriculum that needs to be addressed.

One limitation of quantitative research is that quantitative studies require a larger number of participants, which, depending on the population, can be difficult to obtain (Macur, 2011). Therefore, quantitative data collection could take a considerable amount of time. Additionally, unlike qualitative research, data collected through quantitative methods do not capture the lived experiences of respondents (Queirós et al., 2017). In the current study, this was addressed through the addition of a qualitative question at the end of the quantitative survey so that individual experiences could be examined. Conversely, a limitation of qualitative research is that results are not generalizable to a larger group. The current study addresses this limitation through

the inclusion of quantitative data, which is more generalizable, as well as the large sample size for the qualitative question.

Ethical Considerations

According to the American Counseling Association Code of Ethics (ACA; 2014), researchers must obtain informed consent from participants utilizing clear language (Section G.2.a). Therefore, in the current study, informed consent was obtained prior to data collection. An informed consent document was included at the beginning of the online survey. If the participant decided to proceed, they gave their informed consent by clicking on the link to proceed with the survey.

In order to act in an ethical manner in regard to recruitment, participants were informed that participation in the study was voluntary, and they could withdraw from the study at any time if they became uncomfortable. This is in alignment with the ACA Code of Ethics (2014), which states that participants should be informed that they can discontinue their participation in a study for any reason (Section G.2.a). In addition, the ethical principle of confidentiality in research (ACA, 2014, Section G.1.b) was upheld throughout data collection and data analysis. Names and email addresses of participants were not connected to data in any way, demographic data was presented as aggregate data, and pseudonyms were used in the presentation of qualitative data.

CHAPTER IV: RESULTS

The purpose of this study was to investigate how OCD is taught in graduate counseling programs. In this chapter, the researcher presents data analysis results as they relate to the following research questions: What specific information about OCD is taught to graduate counseling students? and What are the experiences of graduate counseling students learning about OCD? Specifically, this chapter includes a description of the sample, a summary of quantitative results, and a report of qualitative thematic analysis findings.

Demographic Information

One hundred fifty current or recent students in CACREP-accredited graduate counseling programs participated in the online survey. Participants ranged in age from 21 to 56, with the mean age being 31.16. The majority of participants (84.7%) identified as female (n = 127), with the remainder identifying as male (10%), non-binary (4.6%), or other (0.7%). Respondents primarily identified as non-Latinx White (78%), with 6.7% of participants identifying as Black, 5.3% identifying as Asian, 6% identifying as Latinx, 1.3% identifying as American Indian or Alaska Native, and 0.7% identifying as other.

Most participants (78%) were currently enrolled in CACREP-accredited graduate counseling programs, and 22% graduated from a CACREP program within the last two years. Of participants currently enrolled in a graduate program, 7.7% reported being enrolled for less than a year, 40.2% reported being enrolled for one to two years, 47.8% reported being enrolled for two to three years, and 4.3% reported being enrolled for more than three years. Participants who identified as recent graduates of CACREP programs reported the following when asked how long it had been since they graduated: 60.7% graduated less than a year prior to taking the

survey, 15.1% graduated one to two years prior to participating, and 24.2% graduated two years prior to completing the survey.

Factual Reporting of the Project Results

Quantitative Findings

The following research question was addressed through quantitative data collection and analysis: What specific information about OCD is taught to graduate counseling students? Frequency analyses were conducted utilizing participant responses from the OCD Counselor Education Questionnaire. Specifically, the following content areas were analyzed in relation to OCD education: student perceptions of preparedness, course structure, comparison to other diagnoses, OCD subtypes, misdiagnosis, evidence-based treatment, and OCD behaviors.

Student Perceptions of Preparedness

Participants responded to two Likert-scale items related to perceptions of preparedness: (a) My core diagnosis course(s) prepared me to thoroughly understand and diagnose OCD and (b) After taking the core diagnosis course(s), I feel confident in my ability to accurately identify OCD in a client. In response to the first item related to perceived preparedness, 42.3% responded "agree" or "strongly agree." Twenty-three percent responded "neutral." The remaining participants (34.7%) responded "disagree" or "strongly disagree." Participants responded with the following answers when presented with the second item measuring perceived preparedness: 48.7% responded "agree" or "strongly agree" while 25.3% responded "neutral," and 26% responded "disagree" or "strongly disagree."

Course Structure

Participants were asked how much total teaching time was dedicated to OCD in their core diagnosis course, and the following answers were reported: 10.7% indicated less than 15

minutes, 16% indicated 15 to 30 minutes, 22% indicated 30 minutes to one hour, 23.3% reported one to three hours, 8% indicated three or more hours, 4.7% indicated that OCD was not given any time in their diagnosis course, and 14.7% indicated they did not remember how much time was dedicated to OCD.

Participants were also asked who presented the information on OCD in their core diagnosis course. The majority of participants (73.6%) indicated that information on OCD was taught by a course instructor who was not an OCD specialist; 2.9% were taught by a course instructor who was an OCD specialist, 2.9% reported being taught by an OCD specialist guest lecturer, 2.3% were taught by a guest speaker (i.e., individual with OCD), 7.4% reported being taught by a student presentation, and 5.2% indicated that OCD was not taught in their core diagnosis course.

Comparison to Other Diagnoses

Participants reported how much attention OCD received in comparison to the following diagnoses: generalized anxiety disorder, major depressive disorder, posttraumatic stress disorder, bipolar disorders, and eating disorders. In relation to generalized anxiety disorder, 63.3% of participants reported that OCD received less attention or significantly less attention. Compared to major depressive disorder, 66.7% of participants indicated OCD received less attention or significantly less attention. Sixty percent of participants reported that OCD received less attention or significantly less attention than posttraumatic stress disorder. Fifty-six percent indicated OCD received less or significantly less attention than bipolar disorders. Finally, in relation to eating disorders, 33% of participants reported that OCD received less attention or significantly less attention. Full data is presented in Table 1.

Table 1

Attention Given to OCD Compared to Other Diagnoses

Generalized Anxiety Disorder		
	f	Percent
Significantly Less Attention	33	22.000
Less Attention	62	41.333
Equal Attention	39	26.000
More Attention	14	9.333
Significantly More Attention	2	1.333
Major Depressive Disorder		
	f	Percent
Significantly Less Attention	39	26.000
Less Attention	61	40.667
Equal Attention	36	24.000
More Attention	12	8.000
Significantly More Attention	2	1.333
Posttraumatic Stress Disorder		
	f	Percent
Significantly Less Attention	37	24.667
Less Attention	53	35.333
Equal Attention	44	29.333
More Attention	12	8.000
Significantly More Attention	4	2.667

Bipolar Disorders		
	f	Percent
Significantly Less Attention	25	16.667
Less Attention	59	56.000
Equal Attention	52	34.666
More Attention	12	7.333
Significantly More Attention	2	1.333
Eating Disorders		
	f	Percent
Significantly Less Attention	12	8.000
Less Attention	38	25.333
Equal Attention	68	45.333
More Attention	3	19.333
Significantly More Attention	1	2.000

**f* denotes frequency.

OCD Subtypes

Participants were asked if their core diagnosis course covered common subtypes of OCD obsessions and compulsions, and 56.6% of participants answered “no.” Of the participants who indicated their diagnostic course did cover common subtypes of OCD (43.4%), the most frequently reported subtypes taught were ordering and arranging (87.9%), contamination (83.3%), and perfectionism (72.7%). The least commonly reported subtypes taught were sexual orientation (15.2%), existentialism (19.7%), and scrupulosity/morality (27.2%). In addition to these OCD content areas, participants who indicated their diagnosis course covered common OCD subtypes reported whether or not they learned about the following OCD content areas:

harm, aggression, perverse sexual behaviors, fear of losing control, food, just right, death/separation, magical thinking, and hoarding. Frequencies and percentages for all OCD subtypes taught in participants' diagnostic courses can be found in Table 2.

Table 2

OCD Subtypes Taught in Graduate Counseling Programs

Subtypes	*f*	Percent
Contamination	55	83.333
Ordering and Arranging	58	87.879
Harm	33	50.000
Aggression	20	30.769
Perverse Sexual Behaviors	29	43.939
Fear of Losing Control	29	43.939
Perfectionism	48	72.727
Food	33	50.000
Just Right	37	56.061
Scrupulosity/Morality	18	27.237
Death/Separation	28	42.424
Magical Thinking	40	60.606
Sexual Orientation	10	15.152
Hoarding	44	66.667
Existentialism	13	19.697

Misdiagnosis

When asked if their core diagnosis course covered common misdiagnoses of OCD, 46.7% responded "yes." The most frequently reported misdiagnoses taught to participants were generalized anxiety disorder (85.9%) and attention-deficit hyperactivity disorder (57.8%), while the least frequently reported misdiagnoses taught to participants were pedophilic disorder (11.3%) and oppositional defiant disorder (15.5%). Frequencies and percentages for misdiagnoses taught to participants are included in Table 3.

Table 3

Misdiagnoses of OCD Taught in Graduate Counseling Programs

Misdiagnosis	*f*	Percent
Attention-Deficit Hyperactivity Disorder	41	57.746
Generalized Anxiety Disorder	61	85.915
Eating Disorders	28	39.437
Separation Anxiety Disorder	15	21.127
Pedophilic Disorder	8	11.268
Schizophrenia	15	21.127
Sensory Processing Disorder	19	26.761
Oppositional Defiant Disorder	11	15.493

Evidence-Based Treatment

Participants were asked if their core diagnostic course covered evidence-based treatments for OCD, and the slight majority (62%) answered "yes." The most frequently reported treatments of OCD taught to participants who responded "yes" were thought reframing/restructuring (72.3%) and exposure and response prevention (66%). Frequencies and percentages for the

following treatment modalities can be found in Table 4: trauma-focused cognitive behavioral therapy, motivational interviewing, mindfulness, acceptance and commitment therapy, dialectical behavioral therapy, eye movement desensitization and reprocessing, humanistic therapy, solution-focused brief therapy, and psychoanalysis.

Table 4

Evidence-Based Treatment Modalities for OCD Taught in Graduate Counseling Programs

Treatment Modality	*f*	Percent
Thought Reframing/Restructuring	68	72.34
Trauma-Focused Cognitive Behavioral Therapy	32	34.043
Motivational Interviewing	17	18.085
Mindfulness	39	41.489
Exposure and Response Prevention	62	65.957
Acceptance and Commitment Therapy	24	25.532
Dialectical Behavioral Therapy	29	30.851
Eye Movement Desensitization and Reprocessing	21	22.34
Humanistic Therapy	8	8.511
Solution-Focused Brief Therapy	19	20.213
Psychoanalysis	11	11.702

OCD Behaviors

Finally, participants were asked about common OCD behaviors and whether or not these behaviors were taught in their diagnosis course. The first OCD behavior participants were asked about was reassurance seeking, and 35.3% of participants reported this was taught in their diagnostic course. Next, participants were asked about avoidance behaviors as they relate to

OCD, and 48.7% of participants indicated this was taught. Participants were also asked about mental rituals, with 77.3% of participants reporting this was taught in their diagnosis course. Lastly, participants were asked about requests for accommodation from others, and 18.7% responded that they were taught this in their diagnostic course. Almost 15% of participants indicated that none of these OCD behaviors were covered in their core diagnosis course.

Qualitative Findings

The following research question was addressed through qualitative data collection and analysis: What are the experiences of graduate counseling students learning about OCD? At the end of the quantitative survey, participants were asked to describe their experience learning about OCD in their core master's-level counseling course in diagnosis, and all participants completed the question. Several themes emerged in the data through the thematic analysis process. The following themes were identified: (a) overall lack of education, (b) less focus than other disorders, (c) desire for more education, (d) conflict with lived experiences, (e) conflation with anxiety disorders, and (f) positive experiences with OCD specialist lecturers.

Theme 1: Overall Lack of Education

A theme of overall lack of education on OCD emerged in the data. One participant reported that "OCD was not discussed very much in [their] program. Other 'more common' disorders were prioritized." Similarly, one participant stated, "It was not discussed with any depth. What I learned I learned mostly on my own." Other participants described their experiences learning about OCD as "brief," "general," "barely any," and "minimum education about it." One participant wrote,

> I feel like OCD was only covered in a brief manner and while it was definitely spoken about and taught, I do not feel 100% certain I am well-versed in recognizing, diagnosing, and treating OCD based on what we learned from our core diagnosis course.

One participant also shared the following: "I did not acquire much experience when learning about OCD in my course - I was told to read the DSM-5 and the book DSM-5 made easy. This was my only exposure to this diagnosis."

Many participants reported not receiving any education on OCD in their diagnosis course. Another participant shared the following: "Honestly, I don't recall this even being talked about in our dx/assessment classes. Wow, what a blind spot in my education!" Other participants described experiences such as, "We did not discuss this diagnosis specifically at all" and "N/A haven't learned about it at all."

Theme 2: Less Focus Than Other Disorders

Participants also reported that OCD received less focus than other disorders in their core diagnosis courses. One participant said, "It was definitely a lesser focus compared to GAD, MDD, BiPD, etc. No class time was dedicated to the subject. Just course materials (text, maybe a video, and maybe part of a PowerPoint)." Another participant shared a similar sentiment:

> OCD was presented to us alongside other disorders during lecture in class. Not much time was spent on it, and I feel like I know very little about it. Other diagnoses were covered in greater depth, but OCD was not one of them.

Other participants described their experiences learning about OCD in the following ways: "I don't feel that OCD was covered as in depth as other disorders." "We briefly covered as we dove deeper into other diagnoses," and "I remember that we read about OCD in our textbook, but it was not discussed in class like GAD or MDD." Aligning with these remarks, a participant also

wrote, “My experience was that it was not as focused on as other diagnoses and there was very minimally taught with much of the information being surface level information.”

Theme 3: Desire for More Education

When describing their experiences learning about OCD, many participants expressed a desire for more OCD education in their diagnosis course. One participant said, “I wish we went more in depth in OCD. After starting practicum some client with OCD showed signs I thought would be anxiety, I wish we explored it more so I could be more comfortable diagnosing/identifying symptoms.” A participant also wrote, “OCD was covered in my diagnosis class, but not as thoroughly as I would’ve liked. I think often times OCD gets mistaken for GAD. I wish we would have learned more about the subtypes and treatment (such as ERP).” Additionally, another participant shared, “I wish we could have gone more in depth in our course. I feel like it is a common over-looked or misdiagnosed disorder and needs to be thoroughly explained.”

Participants also reported specifically wanting OCD to be covered as a separate lecture or course. A participant wrote the following:

> I feel like I could’ve had a lot more taught to me. OCD was just lumped together with anxiety disorders whenever it was taught to us. I feel like OCD should have its own separate lecture for how complex it can be.

One participant also said, “Looking back, having a whole class on it would have been beneficial.”

Theme 4: Conflict with Lived Experiences

Participants who had lived experiences with OCD (i.e., an OCD sufferer or someone working with the OCD population) shared ways in which their OCD education conflicted with these experiences. One participant shared their experience:

> I am someone that has diagnosed OCD—I was quite disappointed with the way that OCD was presented in my class. The professor essentially presented OCD as a "love of cleaning," and I tried to have a conversation with the professor about this but they were reluctant to listen. I have tried to incorporate OCD into presentations that I have done in my program so that others may learn more about the disorder.

A participant who previously worked with individuals with OCD, wrote:

> I had previous knowledge of OCD based off personal interest in learning about the diagnosis, and from working with patients at my job in an inpatient psychiatric hospital. I feel like these experiences taught me more about OCD and how it presents in individuals with the disorder more than my educational/course experiences in graduate school have taught me. Compared to other diagnoses/disorders, I feel that OCD was not covered as thoroughly as it could have been.

Theme 5: Conflation with Anxiety Disorders

Another theme that emerged in the data was that OCD was often grouped together with anxiety disorders. A participant wrote, "It has not been covered as much as I would like to have learned about it in depth. It was taught alongside anxiety disorders and did not give as much attention to the different types of OCD." Another person said, "It was kinda grouped with our conversation about other anxiety disorders." A participant similarly shared, "OCD was discussed

at the same time as anxiety and other related disorders." Another participant wrote, "It was a general survey of the diagnosis along with similar anxiety diagnoses."

Theme 6: Positive Experiences with OCD Specialist Lecturers

Many participants shared positive and educationally beneficial experiences learning about OCD, primarily in relation to being taught by an OCD specialist. A participant wrote, "I enjoyed learning about it. We had a Psychologist who specializes in researching OCD treatments and has OCD come and do a presentation in my 3 hour long Diagnosis and Treatment course." One person also shared their experience with an OCD specialist guest lecturer:

> I think that we had a really thorough lecture and guest lecture on OCD. Much of the questions asked in this survey were covered and I feel that I (and my colleagues) have a good understanding of the disorder and common treatments.

A participant described their experience learning about OCD as "2 hours of OCD treatment specialist presentation, 1 and a 1/2 hours with professor, homework about diagnosis and treatment plans with the DSM V-TR," and a participant said, "I learned about treatments for OCD from a CBT perspective. My guest lecturer shared her viewpoint on why exposure therapy is very effective."

In the next chapter, salient findings of the current study are discussed in relation to the current literature. The study's limitations are explored, and suggestions for future research are presented. Finally, implications for counselor education and the counseling profession are examined.

CHAPTER V: DISCUSSION

It was hypothesized that the majority of participants would report that OCD received less attention in their diagnostic courses when compared to other mental illnesses. Overall, participants reported that OCD was given less or significantly less attention than generalized anxiety disorder, major depressive disorder, posttraumatic stress disorder, and bipolar disorders in their core diagnosis courses. Most participants reported that OCD received equal or less attention in their course when compared to eating disorders.

High rates of OCD misdiagnosis (Glazier et al., 2013) and excessive latency periods between symptom onset and treatment (Albert et al., 2019) suggest a lack of education on OCD symptomology among clinicians. The current study's findings revealed that diagnostic courses in graduate counseling programs focus less on OCD when compared to other more widely recognized disorders, which could contribute to the misidentification of OCD. Further, results from this study highlight significant gaps in counseling curriculum related to OCD, justifying the need for more attention to be placed on the disorder in diagnosis courses. These specific curriculum gaps will be discussed in the following sections.

This study was conducted using a pragmatic theoretical lens, meaning there was no strict adherence to quantitative or qualitative methodologies. Through the implementation of a quantitative design with a qualitative element, the researcher was able to explore how OCD was taught in graduate counseling programs in a way that allowed for multiple perspectives. Also aligning with pragmatic research, this study addressed real-world problems in a way that has the potential to decrease inequalities among people. This is highlighted through the overarching purpose of the current study, which was to examine OCD education in counselor programs in hopes of decreasing barriers to diagnosis and treatment for a misunderstood population.

Theory and Research

OCD Subtypes

The majority of participants reported they were not taught about common subtypes of OCD obsessions and compulsions in their core diagnosis courses, indicating they were offered a narrow view of OCD symptom presentation. Of participants who reported learning about OCD subtypes, the most frequently taught were ordering and arranging, contamination, and perfectionism. Conversely, the least frequently taught subtypes were sexual orientation, existentialism, and scrupulosity/morality.

Contamination and Ordering/Arranging OCD Subtypes

The most frequently reported OCD subtypes taught in graduate counseling programs were contamination (83.3%) and ordering and arranging (87.9%), which aligns with prior research examining OCD symptom identification. Glazier and McGinn (2015) found that 98.7% of psychology doctoral students were aware of contamination OCD symptoms, and 93.4% were aware of ordering and arranging symptoms. Similar findings were revealed in studies examining OCD symptom identification among mental health professionals, with accurate identification of contamination symptoms ranging from 84.2% (Glazier et al., 2013) to 89% (Perez et al., 2022) and accurate identification of ordering and arranging symptoms at 93% (Perez et al., 2022). The high prevalence of these subtypes being taught in graduate counseling programs may contribute to these symptoms being more readily identified by mental health professionals when compared to other OCD subtypes.

Although these two subtypes are the most widely taught in graduate counseling programs, individuals with OCD experience these symptoms at the same or lower rates than other OCD content areas. In a sample of individuals with OCD, 25.7% reported contamination

symptoms, and 57% reported ordering symptoms (Ruscio et al., 2010). In comparison, 54.4% of participants endorsed taboo OCD symptoms, and 43% endorsed morality symptoms (Ruscio et al., 2010). This suggests that counselors-in-training are presented with a narrow view of OCD symptomology that does not accurately represent the experiences of OCD sufferers.

Aggressive and Sexual OCD Subtypes

Based on the current literature, the author hypothesized that the majority of participants would indicate their diagnostic course did not discuss sexual and aggressive OCD content areas (also known as taboo OCD subtypes), and this was revealed in the study findings. In addition, for participants who reported they were taught about OCD subtypes, the prevalence of subtypes taught aligned with prior research on OCD misdiagnosis rates specifically related to taboo OCD themes. Glazer et al. (2013) found that identification rates were lowest for taboo OCD content areas (23%–57.1%), and Perez et al. (2022) found similar rates, with mental health professionals identifying taboo OCD themes at lower rates (47.3%–58%) when compared to other subtypes. The current study yielded findings that aligned with these identification rates (15.2%–40% for taboo themes), suggesting that misdiagnosis of aggressive and sexual OCD subtypes could potentially be related to how OCD symptomology is taught in diagnosis courses.

These findings are especially significant because aggressive and sexual OCD symptoms are commonly experienced by OCD sufferers. A recent study by Hunt (2020) revealed that 61.9% of participants with OCD endorsed aggressive symptoms and 18.4% endorsed sexual symptoms. Given that the current study's findings indicated that these OCD symptom areas are not frequently taught in graduate counseling programs and that prior studies examining OCD identification rates revealed these subtypes are commonly misidentified, individuals suffering

from aggressive or sexual OCD obsessions and compulsions likely have a greater chance of having their symptoms missed by a mental health professional.

Scrupulosity/Morality OCD Subtype

One surprising finding from the current study was how infrequently participants reported learning about scrupulosity/morality OCD obsessions and compulsions (27.2%), as this differs from identification rates for this subtype found in prior research (65%–71.2%; Glazier et al., 2013; Perez et al., 2022). However, samples from the aforementioned studies encompassed a variety of mental health professionals, including psychologists and psychiatrists, which suggests there may be a larger gap in education on scrupulosity OCD symptoms for counselors, specifically. Moral obsessions and compulsions are also the most common OCD symptoms seen by the author in her clinical practice, aligning with results from the National Comorbidity Survey Replication, which found that moral or religious OCD themes were endorsed by 73.2% of participants with OCD—significantly more than those who endorsed contamination themes (25.7%; Ruscio et al., 2010). The low frequency of learning about this subtype reported by participants in the current study indicates an educational gap in the graduate counseling diagnosis curriculum, especially since moral OCD obsessions and compulsions are frequently experienced by OCD sufferers.

Misdiagnosis

Many participants were not taught about common misdiagnoses of OCD, which has implications for treatment. As previously established, OCD is widely misdiagnosed, and, therefore, it is imperative that clinicians understand common misdiagnoses of OCD (Stahnke, 2021). Oftentimes, a misdiagnosis can lead to ineffective treatment, worsening of OCD

symptoms, and increased stigmatization (Stahnke, 2021), meaning more education on misdiagnosis of OCD is needed in graduate counseling programs.

Of participants who indicated they were taught about common misdiagnoses of OCD in their core diagnosis courses, just under half did not learn that OCD is often misdiagnosed as attention-deficit hyperactivity disorder (ADHD). ADHD and OCD have similar symptom presentations, which often leads to misdiagnosis, especially in children (Abramovitch, 2016). Further, if an individual with OCD is misdiagnosed with ADHD, there can be harmful consequences—particularly if that individual is prescribed stimulant medication—as ADHD medications can exacerbate OCD symptoms (Abramovitch et al., 2013). While ADHD was one of the more widely taught misdiagnoses of OCD compared to other disorders, a large percentage of participants were not taught that ADHD is a common misdiagnosis for OCD. This indicates a potential gap in OCD education that can significantly impact treatment, especially if a client is prescribed medication for ADHD. Clinicians should be aware of this common misdiagnosis in order to ensure clients are receiving the best care possible.

Schizophrenia was largely not reported as a misdiagnosis of OCD taught in participants' graduate programs. Due to the nuance involved in discerning between delusions and obsessions, OCD is misdiagnosed as schizophrenia or, more generally, psychosis (International OCD Foundation, 2018). This misdiagnosis often emerges when clients have lower insight, experience difficulty articulating their obsessions, or have comorbid OCD and autism (Raveendranathan et al., 2012; Ying et al., 2023). Similar to ADHD, medications often prescribed for psychosis worsen OCD symptoms (Leung & Palmer, 2016; Marsanić et al., 2011), which means clinicians should be more aware of potentially harming a client with an inaccurate diagnosis. As many participants were not taught about schizophrenia as a misdiagnosis of OCD in their diagnostic

courses, there is higher potential for misdiagnosis that could prevent clients from accessing appropriate treatment.

The least frequently taught misdiagnosis of OCD was pedophilic disorder, with only 11.3% of participants indicating they were taught this content. Obsessional fears around sexually harming children are common for OCD sufferers and cause significant levels of distress to individuals with this OCD subtype (Bruce et al., 2018). This OCD subtype is highly stigmatized and misunderstood, often leading to increased misdiagnosis and heightened anxiety for individuals with pedophilic-themed OCD (Bruce et al., 2018). Negative impacts of misdiagnosis include worsening of symptoms, treatment dropout, and further stigmatization of individuals with OCD (Vella-Zarb et al., 2017). The current study's findings indicate a significant need for more education on pedophilic disorder as a misdiagnosis of OCD in order to decrease stigma and increase access to effective OCD treatment.

Evidence-Based Treatment

The author hypothesized that exposure and response prevention would not be the most frequently reported evidence-based treatment for OCD taught to participants. Of the participants who said that their core diagnostic course covered evidence-based treatments for OCD, the most frequently endorsed treatment taught to participants was thought reframing/restructuring (72.3%). Exposure and response prevention was the next most frequently reported OCD treatment modality taught to participants (66%). The third most frequently reported OCD treatment was mindfulness (41%).

Exposure and response prevention is considered to be the gold standard treatment for OCD that has been shown to be extremely efficacious (Foa et al., 1984; Franklin et al., 2000; Law & Boisseau, 2019; McKay et al., 2015); however, it was not reported as the most frequently

taught therapeutic modality for treating the disorder. Prior research found that exposure and response prevention was infrequently mentioned by mental health professionals when offering treatment recommendations for OCD (Perez et al., 2022); therefore, it is not surprising that exposure and response prevention was not the most frequently taught evidence-based treatment for OCD in the current study. The current study revealed that the most effective evidence-based treatment for OCD is not the most frequently taught therapeutic modality for this disorder in graduate counseling programs. What is most notable about this finding is that other treatment modalities can increase the severity of OCD symptoms, meaning education on appropriate OCD treatment modalities is essential for proper client care.

Thought reframing/restructuring was the most frequently reported treatment modality for OCD taught in graduate counseling programs. However, general cognitive interventions—such as thought challenging, thought reframing, and thought stopping—are ineffective treatments that often worsen OCD symptoms when they are not tailored specifically to the nuance of OCD treatment (McKay et al., 2021). Even when adjusted to the subtleties of OCD, these techniques are not appropriate standalone interventions but, rather, can be used as adjunct treatments (McKay et al., 2021). This indicates that many counselors-in-training are being taught to provide ineffective, and potentially harmful, treatment to OCD sufferers.

Almost half of the participants (41%) who were taught about evidence-based treatments for OCD reported that mindfulness was taught as an appropriate evidence-based treatment modality. However, mindfulness practices have been shown to be ineffective in treating OCD (McKay et al., 2021), and, overall, individuals with OCD showed a lower level of response to mindfulness techniques when compared to individuals without OCD (Pittig et al., 2013). This

further suggests that students in graduate counseling programs are being presented with ineffective treatment modalities for working with OCD sufferers.

One of the least frequently taught evidence-based treatment for OCD reported by participants was psychoanalysis (11.7%). It is important to note that psychodynamic approaches are harmful as they can exacerbate OCD symptoms and increase the mischaracterization of obsessions and compulsions (McKay et al., 2021). Therefore, since most counselors-in-training are not being taught that psychoanalysis is an appropriate treatment for OCD, there is less potential for the implementation of this harmful treatment modality when clinicians are aware a client has OCD. This could potentially be a problem, however, if a clinician has not accurately identified OCD symptoms in a client and proceeds with psychodynamic approaches. This further emphasizes the need for accurate information on OCD symptom presentation so that individuals with OCD do not receive harmful treatments as a result of a missed diagnosis.

OCD Behaviors

Participants were asked if any of the following common OCD behaviors were taught in their diagnosis courses: reassurance seeking, avoidance, mental rituals, and requests for accommodation from others. While most participants were taught about at least one of these, almost 15% of participants reported they did not learn about any of the presented OCD behaviors. Lack of knowledge around many of these behaviors may contribute to misdiagnosis and inappropriate treatment of OCD.

The majority of participants (64.7%) reported they were not taught about reassurance seeking as it relates to OCD in their diagnosis courses. Reassurance seeking is one of the most common OCD compulsions that provides temporary relief but results in greater levels of anxiety as well as a stronger urge to seek reassurance (Parrish & Radomsky, 2010; Salkovskis & Kobori,

2015). Engaging in that compulsion by providing reassurance to an OCD sufferer has been associated with increased severity of OCD symptoms (Haciomeroglu, 2020). Therefore, if clinicians are unaware of this OCD behavior and unknowingly participate in a client's ritual, they may worsen the client's OCD symptoms. The current study's findings show that many counselors-in-training are not being taught about this common OCD compulsion, which means they may be unaware they are providing treatment in a manner that exacerbates OCD symptoms.

Over half of participants (51.3%) were not taught about OCD avoidance behaviors. Many individuals with OCD engage in avoidance behaviors related to their obsessions and compulsions, and these behaviors have been linked to poorer treatment outcomes (Wheaton et al., 2018). Avoidant behavior in OCD sufferers has also been associated with higher baseline severity of OCD symptoms (Nissen & Parner, 2018). Clinicians should be aware of the impact of OCD avoidance behaviors on treatment outcomes and symptom severity in order to provide appropriate care. The current study, therefore, reveals a lack of education related to avoidance behaviors in OCD that may lead to ineffective treatment of this population.

The large majority of participants (77.3%) reported they were taught about OCD mental rituals in their diagnosis courses. Sibrava et al. (2011) found that mental rituals were the primary OCD symptom for a significant percentage of participants in their study and that these rituals were linked to heightened symptom severity. Other research has also shown mental rituals to be one of the most prevalent OCD symptom presentations (Jaisoorya et al., 2017). Therefore, it is a positive finding that the majority of participants in the current study endorsed learning about mental rituals in their programs.

A significant percentage of participants (81.3%) were not taught about requests for accommodation from others as an OCD behavior. In OCD treatment, accommodation refers to

another person—typically a loved one—assisting the OCD sufferer in performing rituals or avoiding triggering situations (Lebowitz et al., 2012). A recent study by Mahapatra et al. (2020) found that 92% of caregivers provided accommodation to an OCD sufferer, and higher levels of accommodation were associated with higher severity scores on the Yale-Brown Obsessive-Compulsive Scale. Accommodation is prevalent among parents (Lebowitz et al., 2012; Peris et al., 2008), family members (Albert et al., 2017), and romantic partners (Boeding et al., 2013) of individuals with OCD, and decreased accommodation has been linked to improved treatment outcomes (Garcia et al., 2010; Merlo et al., 2009). Therefore, it is significant that accommodation requests were not taught as an OCD behavior to most participants in the current study, especially when considering the high prevalence of the behavior, as well as its impact on OCD severity and treatment outcomes.

Student Perceptions of Preparedness

As explained in the above sections, there appears to be a significant gap in counseling curriculum related to OCD, specifically in regard to the accuracy and scope of content taught in graduate counseling programs. Given that information, it is notable that, when asked if their core diagnosis courses prepared them to thoroughly understand and diagnose OCD, a small percentage of participants (34.7%) said “disagree” or “strongly disagree.” Similarly, when asked if they felt confident in their ability to accurately identify OCD in a client after taking the core diagnosis course, only 26% of participants responded “disagree” or “strongly disagree.” Considering survey responses regarding OCD subtypes, misdiagnosis, evidence-based treatment, and OCD behaviors taught in counseling programs, this indicates a discrepancy between perceived level of preparedness and actual preparedness, suggesting that counselors-in-training believe they are prepared to identify or treat OCD without having the proper information.

These findings also align with the author's experience as an OCD specialist engaging with other mental health professionals. The author has noted that many clinicians express that they believe they are equipped to recognize, diagnose, and treat OCD; however, they often have limited and inaccurate knowledge of OCD symptom presentation, differential diagnosis, and appropriate treatment modalities. Further research is needed to assess if perceived preparedness of counselors-in-training correlates with actual preparedness related to OCD diagnosis.

Qualitative Discussion

Participants were asked to describe their experiences learning about OCD in their diagnosis courses. The author hypothesized that responses to this qualitative question would reveal limited education on OCD in diagnostic classes, and themes identified through the thematic analysis process indicate a lack of OCD education in graduate counseling programs. The following themes emerged in the qualitative data: (a) overall lack of education, (b) less focus than other disorders, (c) desire for more education, (d) conflict with lived experiences, (e) conflation with anxiety disorders, and (f) positive experiences with OCD specialist lecturers.

Theme 1: Overall Lack of Education

Many participants' experiences learning about OCD were described as brief, limited, and general. A common theme that OCD was not taught with any depth emerged in the data. Many participants were not taught about OCD at all in their diagnostic courses. These results align with participant answers on the OCD Counseling Education Questionnaire, which also highlighted a lack of education on OCD. Therefore, quantitative and qualitative findings indicate that OCD is not taught in a way that provides counselors-in-training with sufficient knowledge on how to identify the disorder. This could contribute to the high rates of misdiagnosis for OCD sufferers by mental health practitioners (Glazier et al., 2013; Perez et al., 2022).

Theme 2: Less Focus Than Other Disorders

Participants described their experiences learning about OCD in relation to other disorders, expressing that OCD received significantly less attention than other disorders. This also aligns with the previously described quantitative findings from the OCD Counseling Education Questionnaire. In addition, participants reported that this impacted their ability to learn about OCD, suggesting that OCD should be given more attention in graduate counseling programs to increase understanding of the disorder.

Theme 3: Desire for More Education

Many participants reported a desire for more OCD education in their diagnosis courses. In addition to the current study highlighting a gap in counseling curriculum related to OCD education, it demonstrates that students want to learn more about this disorder. Multiple participants also suggested a separate lecture or course dedicated to OCD. This suggests that greater OCD education would not only address a need in counseling program curriculum but that students would welcome this additional education.

Theme 4: Conflict with Lived Experiences

Participants with OCD lived experiences, either as an OCD sufferer or someone working with the OCD population, expressed disappointment related to how OCD was taught in their diagnosis courses. This suggests that current OCD education does not necessarily align with lived experiences of individuals with OCD or those who work closely with individuals who suffer from OCD.

Theme 5: Conflation with Anxiety Disorders

For many participants, their experiences learning about OCD included the disorder being grouped with anxiety disorders. Historically, OCD was classified under the anxiety disorder

section of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM); however, in 2013, OCD was removed from this section and classified as its own group of disorders (American Psychiatric Association, 2013). While OCD shares characteristics with anxiety disorders, it has its own unique symptomology that manifests differently from anxiety disorders (Abramowitz & Jacoby, 2014). The current study's findings, therefore, suggest that OCD is still being taught in conjunction with anxiety disorders, which could lead to confusion among students and conflation of OCD with anxiety disorders. Further, if OCD is misdiagnosed as an anxiety disorder, clinicians may implement treatment modalities typically used for anxiety disorders that are ineffective or harmful for individuals with OCD.

Theme 6: Positive Experiences with OCD Specialist Lecturers

Finally, participants who learned about OCD from an OCD specialist, either their primary instructor or a guest lecturer, reported positive learning experiences. Participants who shared these experiences reported more time spent on OCD, thorough coverage of the disorder's symptomology, and presentation of appropriate treatment modalities. This suggests that learning about OCD from a specialist has the potential to greatly impact student learning around the disorder.

Limitations and Recommendations

One limitation of the current study is that it did not assess the competence of participants or instructors related to diagnostic ability. Future research should examine the potential link between OCD curriculum in counselor education programs and student diagnostic skills related to OCD. Another avenue for future research is an exploration of the diagnostic competence of counselor educators related to OCD. Counseling programs could also utilize the OCD Counselor Education Questionnaire to assess their own teaching of OCD in diagnostic coursework.

The study included a heterogenous sample that did not fully align with demographics of counseling students reported by CACREP (2022). This could limit generalizability to diverse populations. Future research could focus on obtaining a more diverse sample that is more representative of counseling students enrolled in CACREP-accredited counseling programs.

Participants were considered eligible if they identified as a recent graduate of a CACREP-accredited counseling program, meaning they may have completed their program up to two years prior to taking part in the survey. Since the current study did not inquire about the timing of when participants took their diagnosis course, it is possible that a significant amount of time had passed since some participants learned about OCD. For that reason, the gap in time between attending the course and completing the survey could have potentially impacted the memory of participants. Future research could replicate this study using solely students who had recently completed their diagnosis course to ensure better recall of material taught and to further validate results of the current study.

Finally, while the current study identified a gap in the counseling curriculum, it did not assess interventions designed to reduce that gap. Therefore, further research is needed to examine the efficacy of accurate OCD education curriculum in graduate counseling programs, particularly in diagnostic coursework. Knowledge, stigma, and diagnostic application could all be assessed in future works related to the effectiveness of OCD curriculum delivery.

Importance of the Findings and Implications

A lack of clinician education on OCD is a problem that impacts counselor education, clinical practice, and individuals with OCD. Addressing this dearth of knowledge related to OCD has potential to decrease exorbitant rates of OCD misdiagnosis as well as reduce the latency period between OCD onset and treatment for OCD sufferers. When looking at the overall picture

presented by both quantitative and qualitative results, the current study highlights a gap in the graduate counseling curriculum that could explain the widespread lack of knowledge among mental health clinicians.

Implications for Social Justice and Advocacy

Individuals with OCD experience significant barriers to diagnosis and treatment. The current study highlighted a lack of appropriate education on OCD for counselors-in-training, which likely contributes to the obstacles faced by OCD sufferers. It is important that counselor educators and clinicians advocate for the proper diagnosis and treatment of individuals with OCD in order to ensure they receive appropriate care. Social justice and advocacy efforts could include comprehensive trainings for clinicians, more thorough OCD education in counseling programs, workshops for community leaders, conversations with other professionals about OCD symptomology, and psychoeducation for clients. These advocacy efforts are especially important in communities of color, as BIPOC individuals often experience greater barriers to OCD treatment (Chasson et al., 2017). Therefore, resources should incorporate culturally relevant information on OCD, including how culture impacts OCD symptom content area (Al-Solaim & Loewenthal, 2011; Ching & Williams, 2019; Wetterneck et al., 2011) as well as how OCD can mimic cultural norms (Nicolini et al., 2017; Williams & Jahn, 2017; Wu & Wyman, 2016). This could potentially reduce misdiagnosis in BIPOC communities, specifically. Advocating for individuals with OCD has potential to increase symptom identification and access to care while reducing stigma and misdiagnosis. OCD social justice and advocacy efforts should begin in counselor education programs in order to promote more widespread advocacy efforts.

Implications for Counselor Education

The current study's findings reveal a blind spot in master's-level counseling programs, particularly related to OCD symptom presentation, misdiagnosis, and treatment modalities. As a result, counseling programs are offering incomplete training to their students that does not adequately prepare them to diagnose and treat a prevalent mental health concern. Further, the lack of focus on OCD in these programs perpetuates misdiagnosis of the disorder and possibly promotes harmful treatment for individuals with OCD. Counseling programs should provide training to counselor educators to ensure proper education on the disorder. In addition, counselor educators who teach diagnostic coursework should utilize guest lecturers—either OCD specialists or individuals with OCD—when discussing OCD symptom presentation. If counseling programs implement an accurate OCD curriculum in diagnosis courses, students will be better prepared to identify OCD in their clients, have a better understanding of appropriate evidence-based treatments for OCD, and be better equipped to work with OCD sufferers in a way that does not reinforce their symptoms or cause harm.

Implications for Clinical Practice

As supported by the current study's findings, counseling students and recent graduates desire more education on OCD in graduate counseling programs. Without this targeted education, mental health clinicians have a significant gap in their ability to diagnose and treat the OCD population. This could lead to feelings of inadequacy when a client is not progressing in treatment, or even deteriorates throughout treatment, due to misdiagnosis or inappropriate care. Proper education on OCD can also limit the chances that a practitioner will provide a highly stigmatizing diagnosis, such as pedophilic disorder, to a client who is experiencing OCD symptoms. Finally, receiving accurate OCD training can help counselors better operate within

their scopes of practice because they will be aware of the nuance of OCD treatment and the potential harm that can come to clients who receive inappropriate treatment modalities. Therefore, clinicians should seek continuing education on OCD in order to provide proper diagnosis and treatment for OCD sufferers.

Implications for Individuals with OCD

Individuals with OCD experience significant distress related to their obsessions and compulsions, and, if left untreated, OCD symptoms will continue to progress throughout the individual's life (Fineberg et al., 2019). As an OCD specialist, the author frequently encounters individuals who, over the course of years, have received inaccurate diagnoses, experienced improper treatment, and internalized feelings of hopelessness that their symptoms would never improve. Literature related to the latency period between OCD symptom onset and treatment, as well as research around OCD misdiagnosis, highlights these same issues. For OCD sufferers, there are significant benefits that can be yielded from increased education on OCD in graduate counseling programs. According to epidemiological data, OCD affects over seven million people in the United States (Ruscio et al., 2010). However, these statistics only encompass individuals who have received an OCD diagnosis. Since the disorder is so widely misunderstood and misdiagnosed, it can be inferred that more people suffer from OCD than is reflected in these numbers. This means that many individuals unnecessarily suffer for years before receiving appropriate care, if they receive it at all. If clinicians are better trained to identify OCD and to understand evidence-based treatments for the disorder, OCD sufferers will be able to experience a shorter duration of symptoms, reduced stigma related to their symptoms, and relief that comes from having an explanation for their symptoms. Increased education will also reduce the potential for harm to be caused through improper treatment and misdiagnosis. By implementing

an accurate and comprehensive OCD curriculum within graduate level diagnostic courses, program directors, counselor educators, counselors-in-training, and current practitioners can ensure that individuals with OCD do not wait years to receive help and, instead, can find relief for their highly distressing symptoms.

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APPENDIX A: IRB Approval Documentation

ANTIOCH UNIVERSITY
SEATTLE

2400 3rd Avenue, Suite 200, Seattle, Washington 98121 | 206.441.5352 | antioch.edu/seattle

March 7, 2023

To Whom It May Concern,

Please be advised that the research project submitted by Laura Smestad, entitled *How is Obsessive-Compulsive Disorder Taught in Graduate Counseling Programs?* has been approved by the Institutional Review Board of Antioch University Seattle.

Should you have any questions regarding this approval process, please feel free to contact me.

Sincerely,

Melissa Kennedy, PhD

Melissa Kennedy, PhD
Institutional Review Board Chair
Core Faculty Member, Psy.D. Doctorate in Clinical Psychology (APA-accredited)
Antioch University Seattle

APPENDIX B: Sociodemographic Questionnaire

Please complete the following information.

Age: _____

Gender: □ Male □ Female □ Non-binary □ Other (Specify): _____

Which of the following best describes you?
□ Black □ Latinx □ White (non-Latinx) □ Asian
□ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander

Are you currently enrolled in a CACREP-accredited counseling program?
□ Yes, I'm currently enrolled □ No, I've graduated

How long have you been enrolled in your current CACREP-accredited counseling program?
□ less than 1 year □ 1-2 years □ 2-3 years □ more than 3 years

How long has it been since you graduated from a CACREP-accredited counseling program?
□ less than 1 year □ 1 year □ 2 years

APPENDIX C: The OCD Counselor Education Questionnaire

Please answer the following questions based on your experience in any core master's-level counseling courses in diagnosis (i.e., psychopathology, diagnosis and treatment of mental disorders, or other equivalent non-elective class meeting CACREP standards for diagnosis coursework):

1. My core diagnosis course(s) prepared me to thoroughly understand and diagnose obsessive-compulsive disorder (OCD).
    - ☐ Strongly agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly disagree

2. After taking the core diagnosis course(s), I feel confident in my ability to accurately identify OCD in a client.
    - ☐ Strongly agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly disagree

3. Approximately how much total teaching time was dedicated to OCD in your program's core diagnosis course(s)?
    - ☐ None
    - ☐ Less than 15 minutes
    - ☐ 15-30 minutes
    - ☐ 30 minutes to 1 hour
    - ☐ 1-3 hours

☐ 3+ hours

☐ I do not remember

sss

4. How much attention **did OCD receive** in your core diagnosis course(s) when compared to the following diagnoses?:

	Significantly Less Attention	Less Attention	Equal Attention	More Attention	Significantly More Attention
Generalized Anxiety Disorder					
Major Depressive Disorder					
Posttraumatic Stress Disorder					
Bipolar Disorders					
Eating Disorders					

5. Who presented the information on OCD in your core diagnosis course(s)? (check all that apply)

☐ Course instructor (non-OCD specialist)

☐ Course instructor (OCD specialist)

☐ Guest lecturer (OCD specialist)

☐ Guest speaker (i.e., individual with OCD)

☐ Student presentation

☐ N/A–this information was not presented

☐ Other (please specify): _____

6. Did your program's diagnosis course(s) cover common subtypes of OCD obsessions and compulsions?

    ☐ Yes

    ☐ No

7. Which of the following subtypes of OCD obsessions and compulsions were explicitly mentioned in your program's core diagnosis course(s) [***specifically related to OCD content***]? (check all that apply)

    ☐ Contamination (e.g., fear of germs/illness)

    ☐ Ordering and arranging (e.g., need for exactness or symmetry)

    ☐ Harm (e.g., fear of harming oneself, fear of harm coming to loved ones)

    ☐ Aggression (e.g., fear of harming others)

    ☐ Perverse sexual behaviors (e.g., rape, incest, pedophilia)

    ☐ Fear of losing control (e.g., fear of jumping off a bridge)

    ☐ Perfectionism (e.g., obsession with things being perfect)

    ☐ Food (e.g., foods being "right" or "wrong," restrictive eating)

    ☐ "Just right" (e.g., doing things until they feel "right")

    ☐ Scrupulosity/morality (e.g., fear of being a bad person or offending God)

    ☐ Death/separation (e.g., fear of family member dying)

    ☐ Magical thinking (e.g., superstitious behaviors to prevent bad things)

    ☐ Sexual orientation (e.g., fear of sexual orientation changing)

    ☐ Hoarding (e.g., excessive saving of items)

    ☐ Existentialism (e.g., obsessions around existential questions)

8. Did your program's diagnosis course(s) cover common misdiagnoses of OCD?

    ☐ Yes

    ☐ No

9. If yes, which of the following were presented as common misdiagnoses for OCD? (check all that apply)

    ☐ Attention deficit disorder

    ☐ Generalized anxiety disorder

    ☐ Eating disorders

    ☐ Separation anxiety disorder

    ☐ Pedophillic disorder

    ☐ Schizophrenia

    ☐ Sensory processing disorder

    ☐ Oppositional defiant disorder

    ☐ Other (please specify): _____

10. Did your program's diagnosis course(s) discuss evidence-based treatments for OCD?

    ☐ Yes

    ☐ No

11. If yes, which modalities were taught as evidence-based treatments for OCD? (check all that apply)

    ☐ Thought reframing/restructuring

    ☐ Trauma-focused cognitive behavioral therapy

    ☐ Motivational interviewing

    ☐ Mindfulness

    ☐ Exposure and response prevention

    ☐ Acceptance and commitment therapy

    ☐ Dialectical behavioral therapy

    ☐ Eye movement desensitization and reprocessing

    ☐ Humanistic therapy

    ☐ Solution-focused brief therapy

☐ Psychoanalysis

12. Which of the following behaviors typically exhibited by individuals with OCD were explained (as they relate to OCD) in your program's diagnosis course(s)? (check all that apply)

    ☐ Reassurance seeking

    ☐ Avoidance

    ☐ Mental rituals

    ☐ Requests for accommodating behaviors from others

Please describe your experience learning about OCD in your core master's-level counseling course in diagnosis:

_____

_____

APPENDIX D: Informed Consent

Study Title:
How is Obsessive-Compulsive Disorder Taught in Graduate Counseling Programs?

This study will assess how obsessive-compulsive disorder (OCD) is taught in graduate counseling programs. The survey you are about to complete will provide an opportunity to participate in research aimed at identifying potential gaps in counseling curriculum as well as reducing barriers to diagnosis and treatment for individuals with OCD.

You qualify for this study if you meet the following criteria: (1) current or recent (graduated in the last two years) student in a CACREP-accredited clinical mental health counseling program and (2) completion of a synchronous master's-level counseling course in psychopathology, diagnosis, or other equivalent class meeting CACREP standards for diagnosis coursework. Individuals are excluded from participating if they attend(ed) Antioch University Seattle (AUS).

There are minimal, if any, risks from participating. Your identity will be anonymous. You will not be asked for your name, and no personally identifiable information will be associated with your responses to any reports of this data.

The survey will take approximately 5-10 minutes to complete.

At the end of the questionnaire, you will have the option of entering your email address to enter a raffle for an $80 Amazon gift card.

Your participation is voluntary and can be discontinued at any time.

If you have any questions about the survey or the research study, please contact the primary researcher: Laura Smestad.

This project has been approved by the Institutional Review Board at Antioch University. If you have any questions about your rights as a research participant, please contact Melissa Kennedy. For other concerns, please contact the study's research advisor, Dr. Katherine Fort.

I have read and understood the above information.

By clicking "Next" below, I am indicating that I have read and understood this consent form and agree to participate in this research study. Please print a copy of this page for your records. Thank you for your participation!

APPENDIX E: Participant Recruitment Email

To whom it may concern:
I am a doctoral candidate in the counselor education and supervision program at Antioch University Seattle, and I am seeking participants for my dissertation on how obsessive-compulsive disorder (OCD) is taught in graduate level counseling programs. I'm writing in hopes that you will be willing to share the following participant recruitment email with your graduate counseling students (master's level). Your students' participation will potentially inform future counselor education program development and identify gaps in counseling curriculum related to OCD. Please reach out to me if you have any questions regarding this study.
Thank you for your consideration.
Sincerely,
Laura Smestad

You are invited to participate in a research study titled, *How is Obsessive-Compulsive Disorder Taught in Graduate Counseling Programs?*. This project is part of the School of Applied Psychology, Counseling, and Family Therapy Ph.D. Counselor Education & Supervision Program at Antioch University Seattle.
Your responses will help identify potential gaps in counseling curriculum related to OCD, which may reduce barriers to diagnosis and treatment for individuals with OCD.
You are eligible to participate in this study if you meet the following criteria:

1) **current or recent (graduated in the last two years) student in a CACREP-accredited clinical mental health counseling program**
2) **completion of a synchronous master's-level counseling course in psychopathology, diagnosis, or other equivalent class meeting CACREP standards for diagnosis coursework**

Individuals are excluded from participating if they attend(ed) Antioch University Seattle (AUS).
Please consider completing the following survey. It should take between 5 and 10 minutes to complete.
Participants will have the chance to be entered into a drawing for an $80 Amazon gift card.
If you would like to participate, please follow this link to complete the survey about your experiences. Follow this link to participate:
https://qfreeaccountssjc1.az1.qualtrics.com/jfe/form/SV_bvV4q55Uafkbq5g
Thank you for your time and consideration!
If you have any questions about the survey or the research study, please contact the primary researcher: Laura Smestad.

This project has been approved by the Institutional Review Board at Antioch University. If you have any questions about your rights as a research participant, please contact Melissa Kennedy. For other concerns, please contact the study's research advisor, Dr. Katherine Fort.