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Student Perceptions of How Obsessive-Compulsive Disorder is Taught in Graduate Counseling Programs

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Obsessive-compulsive disorder (OCD) is a widely misunderstood and misdiagnosed mental health condition. Researchers have found significant delays between the first occurrence of OCD symptoms and treatment, likely due to high rates of misidentification of the disorder by healthcare providers. This study investigated student perceptions of how OCD is taught in graduate counseling programs. A mixed-methods approach was used to examine students' recollections of specific information taught about OCD in graduate counseling programs as well as their experiences learning about OCD. Participants completed the OCD Counselor Education Questionnaire to assess their perceptions of 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 and misdiagnosis, as well as an overall lack of education on OCD.

Keywords: obsessive-compulsive disorder, OCD, counselor education, student

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Obsessive-compulsive disorder (OCD) 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). It 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). 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 sexual and aggressive content; Glazier et al., 2013). This suggests that more comprehensive education on OCD, specifically related to taboo content areas, can significantly increase the identification of the disorder. Further, increased early identification of OCD has the potential to decrease the severity of OCD symptoms, improve clinical outcomes, and prevent chronic development of the disorder (Fineberg et al., 2019). However, studies across countries show that, on average, individuals with OCD wait seven to ten years after first experiencing symptoms before receiving appropriate treatment (Albert et al., 2019; Hezel et al., 2022; Marques et al., 2010; Stengler et al., 2013).

This excessive latency period, as well as the high rate of misdiagnosis (Perez et al., 2022), is likely related to scarcity of clinician education on the disorder. 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.

Neukrug et al. (2013) sought to identify the most commonly taught assessment instruments in master's-level counseling courses. A total of 210 counselor educators reported 174 instruments, none of which were OCD-related. The questionnaire used in this study was developed through examination of four textbooks predominantly utilized by counselor educators (Neukrug et al., 2013), suggesting that OCD assessment instruments may not be widely taught. Therefore, by examining how OCD is presented in graduate counseling programs, a curriculum gap could be identified that indicates a need for more comprehensive education on OCD. The current study sought to understand student perceptions of how OCD is taught in graduate counseling programs as well as to identify potential curriculum gaps.

Method

The study aimed to answer the following research questions using a mixed-methods design: (a) What do graduate counseling students recall being taught about OCD in their programs? and (b) What are graduate counseling students' experiences learning about OCD? The first question was answered through quantitative items on the *OCD Counselor Education Questionnaire,* and the second question was examined through a qualitative question at the end of the survey.

Participants

This study included a sample of 150 participants, aligning with prior studies utilizing a sample of graduate counseling students (Barden & Greene, 2015; Mullen et al., 2015; Person et al., 2020). 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 clinical mental health counseling program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and (b) completion of a synchronous master's-level counseling course in psychopathology, diagnosis, or other equivalent class meeting CACREP standards for diagnostic coursework. Participants had the option to be entered into a drawing to receive an $80 Amazon gift card as compensation for their participation. Participants ranged in age from 21 to 56, with the mean age being 31.16. Other demographic information can be found in Table 1.

Table 1

Participant Demographic Information

Gender		
	f	Percent
Woman	127	87.400
Man	15	10.000
Non-Binary	7	4.600
Other	1	0.700
Race/Ethnicity		
	f	Percent
Non-Latinx White	117	78.000
Black	10	6.700
Asian	8	5.300

Latinx	9	6.000
American Indian/Alaska Native	2	1.333
Other	1	0.700

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 a graduate program or time since graduation.

The OCD Counselor Education Questionnaire

The OCD Counselor Education Questionnaire (OCEQ; Smestad, 2023) is a 12-item self-report survey that measures students' perceptions of how OCD is taught in graduate counseling programs. 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 (e.g., "Which of the following subtypes of OCD obsessions and compulsions were explicitly mentioned in your program's core diagnosis course?"), and student perceptions of preparedness. The OCEQ also includes a qualitative question that explores individual experiences of students, asking them to describe their experience of learning about OCD in their core master's-level counseling course in diagnosis. Participants were instructed to answer all items on the questionnaire based on their experience in any core master's-level counseling courses in diagnosis.

The OCEQ has demonstrated adequate reliability (Smestad, 2023). In a reliability study by Smestad (2023), participants completed the OCEQ at two points: once at the beginning of the study and again 15 days later. Participant answers between the two

survey attempts were compared, and a Pearson product-moment correlation coefficient was calculated. 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. The current study did not reassess the instrument's reliability; however, the previously established test-retest reliability supports the appropriateness of the OCEQ for use in this context.

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 also given when participants proceeded to the sociodemographic questionnaire and the OCEQ.

Data Analysis

Quantitative survey data were analyzed using Jeffrey's Amazing Statistical Program (JASP Team, 2024), a free, open-source statistical analysis software similar to Statistical Package for Social Sciences (SPSS). Prior to analysis, the dataset was systematically cleaned to address incomplete responses; specifically, cases with missing data due to survey non-completion were excluded. This resulted in a final sample of 150 participants out of the initial 176 respondents. Demographic constructs were transformed

into numerical values using JASP's export feature. The data analysis process involved the use of descriptive statistics and frequency analyses to provide a summary of the dataset's characteristics as well as to examine the prevalence with which students endorsed individual items on the questionnaire.

The qualitative data obtained from the open-ended survey question were analyzed using thematic analysis, which is commonly used in mixed-methods research (Clarke & Braun, 2017). The analysis followed the six-phase process outlined by Braun and Clarke (2006): (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. Thematic analysis is considered a flexible process in which researchers identify themes based on patterns; therefore, details such as the number of participants who reported specific themes or the presence of contradictory statements are not identified when using this method (Terry & Hayfield, 2021). In the current study, the data were categorized into themes until the phenomena were merged. Throughout the qualitative analysis process, the researcher engaged in reflexive practices and discussed experiences with a research mentor to check for possible biases and increase trustworthiness of the data. Qualitative and quantitative data were analyzed separately. Qualitative data were then triangulated by cross-checking findings with quantitative results.

Results

Quantitative Findings

The first research question was answered through quantitative data collection and analysis. Specifically, the following content areas were analyzed in relation to OCD

education: student perceptions of preparedness, comparison to other diagnoses, OCD subtypes, misdiagnosis, and OCD behaviors. The following results offer insight into the nature of OCD-related education reported by students across these domains.

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."

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 or significantly less attention. Compared to major depressive disorder, 66.7% of participants indicated that OCD received less or significantly less attention. Sixty percent (60.0%) of participants reported that OCD received less or significantly less attention than posttraumatic stress disorder. Fifty-six percent (56.0%) 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 or significantly less attention.

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 that their diagnostic course covered 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%). 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%).

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. Lastly, participants were asked about requests for accommodation from others, and 18.7% responded that they had been taught this in their diagnostic course. Almost 15% of participants indicated that none of these OCD behaviors were covered in their core diagnosis course(s).

Qualitative Findings

The second research question was answered through qualitative data collection and analysis. Four themes emerged in the data through the thematic analysis process: (a)

lack of education, (b) desire for more education, (c) conflation with anxiety disorders, and (d) positive experiences with OCD specialist lecturers.

Theme 1: Lack of Education

A theme of lack of education on OCD emerged in the data. One participant reported that "OCD was not discussed very much in [their] program." 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," and "barely any." 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."

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 described their experiences learning about OCD in the following way: "I don't feel that OCD was covered as in depth as other disorders." 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."

Theme 2: 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." Another participant stated, "Looking back, having a whole class on it would have been beneficial."

Theme 3: 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."

Theme 4: 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 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." Another 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."

Discussion

Quantitative Discussion

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. 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. Although these two subtypes are the most widely taught, individuals with OCD experience these symptoms at the same or lower rates than other OCD content areas (Ruscio et al., 2010).

Consistent with current literature, the majority of participants indicated their diagnostic course(s) did not discuss sexual and aggressive OCD content areas (taboo OCD subtypes). 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. Glazier et al. (2013) found that identification rates were lowest for taboo OCD content areas (23%–57.1%). 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 is taught in diagnosis courses.

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, suggesting there may be a larger gap in education on scrupulosity OCD symptoms for counselors, specifically. Moral obsessions and compulsions are also some of the most common OCD symptoms, and, in prior research, these themes were endorsed by 73.2% of participants with OCD, significantly more than those who endorsed contamination themes (25.7%; Ruscio et al., 2010).

Misdiagnosis

Many participants were not taught about common misdiagnoses of OCD. As previously established, OCD is widely misdiagnosed, and, therefore, it is imperative that clinicians understand common misdiagnoses so that it does not lead to ineffective treatment, worsening of OCD symptoms, or increased stigmatization (Stahnke, 2021). 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 lead 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).

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 can be misdiagnosed as schizophrenia (Hudak, 2018). This misdiagnosis often emerges when clients have lower insight, have trouble articulating their obsessions, or have comorbid OCD and autism (Ying et al., 2023). Like ADHD, medications often prescribed for psychosis worsen OCD symptoms (Leung & Palmer, 2016).

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 and further stigmatization of individuals with OCD (Vella-Zarb et al., 2017). The current study's findings indicate a need for more education on pedophilic disorder as a misdiagnosis of OCD to decrease stigma and increase access to treatment.

OCD Behaviors

Participants were asked if any of the following common OCD behaviors were taught in their diagnosis courses: reassurance seeking, avoidance, and requests for accommodation from others. While most participants were taught at least one of these, almost 15% of participants reported they did not learn about any of the presented OCD behaviors. 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 (Salkovskis & Kobori, 2015). Engaging in reassurance 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. Similarly, 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).

A significant percentage of participants (81.3%) were not taught about requests for accommodation from others as an OCD behavior. A 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 (Peris et al., 2008), family members (Albert et al., 2017), and romantic partners (Boeding et al., 2013). 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 regarding 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, 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.

Qualitative Discussion

In line with the quantitative results, many participants' experiences learning about OCD were described as brief, limited, and general, and many participants were not taught about OCD at all in their diagnostic courses. Additionally, participants described their experiences learning about OCD in relation to other disorders, expressing that OCD received significantly less attention than other mental health diagnoses. Participants reported that this impacted their ability to learn about OCD, suggesting that OCD should be given more attention in counseling programs to increase understanding of the disorder. Many participants also reported a desire for more OCD education in their diagnosis courses. Although no studies to date have specifically explored students' experiences

learning about OCD, researchers have examined the efficacy of proper OCD education. In a study by Glazier and McGinn (2015), psychology doctoral students initially showed limited awareness of OCD symptoms beyond contamination and symmetry, often misdiagnosing other subtypes; however, misidentification rates significantly decreased after watching an educational video on OCD. Consistent with these findings, previous research has identified insufficient clinician knowledge as a substantial barrier to accurate diagnosis and effective treatment of OCD (Senter et al., 2021; Vuong et al., 2016). As such, participants in the current study who reported minimal or superficial training in OCD may be less equipped to recognize the full range of symptom presentations.

Many participants indicated that, in their training, OCD was taught as part of the broader category of 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 (McKay et al., 2021).

Finally, participants who learned about OCD from an OCD specialist reported positive learning experiences, more time spent on OCD, thorough coverage of the

disorder's symptoms, and presentation of appropriate treatment modalities. As previously noted, OCD misdiagnosis remains prevalent among mental health professionals (Glazier et al., 2013; Perez et al., 2022). This suggests that general practitioners may not possess a comprehensive understanding of the full range of OCD symptoms required for accurate and effective teaching. Consequently, receiving education on OCD from a specialist may significantly enhance students' understanding of the disorder.

Limitations and Recommendations

One limitation of the current study is that it did not assess the diagnostic competence of participants. Future research should examine the potential link between OCD learning experiences in counselor education programs and student diagnostic skills related to OCD. In addition, another limitation to this study is that it focused solely on student perceptions of how OCD was taught. Future studies may examine course materials and syllabi used to teach OCD to graduate counseling students. Further, while the current study identified a potential gap in the counseling curriculum, it did not evaluate interventions designed to address that gap. Therefore, further research is needed to examine the efficacy of accurate OCD education curriculum in graduate counseling programs, particularly in diagnostic coursework. Finally, the qualitative findings were based on responses to a single open-ended survey question, limiting the depth of insight obtained. Future research should aim to explore more thoroughly the lived experiences of students learning about OCD.

Implications for Counselor Education

The current study's findings reveal a blind spot in master's-level counseling programs, particularly related to the teaching of OCD symptom presentation and

misdiagnosis. 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. The lack of focus on OCD in these programs perpetuates misdiagnosis of the disorder and possibly promotes harmful treatment for individuals with OCD (McKay et al., 2021). Counseling programs should provide training for counselor educators to ensure proper education on the disorder. Counselor educators who teach diagnostic coursework should utilize guest lecturers, either OCD specialists or individuals with OCD, when discussing OCD symptom presentation. Further, Black, Indigenous, and People of Color (BIPOC) individuals often experience greater barriers to OCD treatment (Chasson et al., 2017). Therefore, curriculum related to how culture impacts OCD symptoms have the potential to reduce misdiagnosis in BIPOC communities, specifically. 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.

Conclusion

This study demonstrates gaps in graduate counseling program diagnostic coursework based on student perceptions of how OCD is taught. Counseling programs should provide training to ensure proper education on the disorder, utilizing either OCD specialists or individuals with OCD. If clinicians are better trained to identify OCD, 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 caused by 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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