See article by Glazier et al

What to Make of Misidentification Rates in Obsessive-Compulsive Disorder

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Glazier and colleagues[1] describe the considerable difficulty exhibited by nonpsychiatrist physicians in correctly identifying obsessive-compulsive disorder (OCD) caseness and show that misidentification was associated with treatment recommendations that were not evidence based. While disconcerting, the findings are not particularly surprising and are suggestive of significant gaps in mental health training and care that, while specific to OCD in this report, most likely transcend to other psychiatric disorders.

Rates of OCD misdiagnosis by nonpsychiatrist physicians, especially for less well-advertised symptoms (eg, sexual or aggressive obsessions), were startling and may reflect limited breadth of medical school/residency training curricula and continuing education in psychiatry. Mental health problems are a leading cause of disability among youth and adults.[2,3] Yet, nonpsychiatrist physicians have very limited training in and exposure to psychopathology and mental health treatment during medical school and residency despite the common incidence. Medical school students complete extremely brief clerkships in psychiatry, while residents often receive even less formal training/exposure while pursuing specialty training in their respective discipline. What exposure is provided has considerable heterogeneity across training programs and most likely depends on interdisciplinary relationships with teaching psychiatry/psychology departments and the resources within these departments (eg, presence of an on-site OCD clinic).

To improve on OCD recognition, training during medical school, residency, and beyond must be more comprehensive and diverse than what current curricula entail, especially for certain disciplines that may commonly interface with OCD and related disorders (eg, body dysmorphic disorder) such as obstetricians, pediatricians, dermatologists, and general practitioners, among others. For example, there has been recent recognition of postpartum OCD[4]; yet obstetricians frequently misdiagnose or fail to diagnose OCD, and as a result, they administer the wrong treatment or no treatment and often stigmatize the patient (eg, considering a mother with harm obsessions as a threat to her child). Diversifying continuing education efforts such that nonpsychiatrist providers are required to take coursework in mental health would be a well-advised way to disseminate information across disciplines, especially to those with greater chance of interfacing with individuals with OCD.

Beyond the high misdiagnosis rates, it was quite concerning how vignettes were misidentified in Glazier et al[1] (eg, with schizophrenia, pedophilia). The fields of medicine and other applied health professions have the primary goal of alleviating suffering. Yet, application of grossly inaccurate diagnoses accomplishes the exact opposite by misdirecting treatment plans, exposing the patient to potentially harmful or ineffective interventions, stigmatizing the patient (and family), and reducing patient hope. Further, it has the additional consequence of marginalizing the field of psychiatry as a result of prescribed interventions that are ineffective for the patient because they are not the correct approach. In such an instance, the affected individual and provider may erroneously conclude that treatment is ineffective, compounding unnecessary suffering and impairment while incorrectly advancing the notion that mental health interventions are less likely to be successful. In some instances—especially involving more taboo obsessive-compulsive symptoms (eg, involving harming others or inappropriate sexual behaviors toward others)—misdiagnosis and the associated urgency to intervene may result in a disastrous outcome should the individual be referred for evaluation by a protective agency that may have little OCD experience. On balance, simply recognizing there is a problem may be adequate, provided the physician refers the individual to a qualified mental health clinician for evaluation and treatment planning. However, data from Glazier et al[5] and others[6] highlight concerns that mental health providers are not sufficiently equipped to adequately assist individuals with OCD. Addressing the wide disparity in OCD expertise among mental health clinicians is a major challenge but necessary for mental health disciplines to garner respect from outside payers, reduce stigma associated with treatment seeking, and improve patient outcomes.

The treatment recommendations provided by respondents could be construed in both a positive and negative light. On the positive, that cognitive-behavioral therapy (CBT), either alone or with a serotonin reuptake inhibitor (SRI), was recommended by a significant number of physicians (even when misidentifying the case) is suggestive of successful dissemination of knowledge about this treatment modality, which has been the result of a robust effort by advocacy agencies (eg, International OCD Foundation). On balance, it is unlikely that CBT is accessible to most patients, especially those with fewer financial resources. As a result, many individuals with OCD go untreated or are treated with SRI monotherapy, non-CBT psychotherapy, or both,[7]

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although practice guidelines clearly indicate the role of CBT monotherapy for mild/moderate severity cases and together with SRI medications in the most severely affected.[8,9] Although CBT was named by many physicians, it is unclear if they were aware of what comprises this intervention. Many, including mental health professionals, use the name CBT but fail to include the most robust treatment element, exposure and response prevention, a practice that speaks to the need for continuity across training programs. On the less positive side, a sizable number of respondents still recommended non-evidence–based psychotherapy and/or pharmacologic approaches, suggesting that more needs to be done to convey information about effective, comprehensive intervention that is consistent with patient preference.[10]

In sum, Glazier et al[1] bring important attention to the issue of OCD misdiagnosis and treatment recommendations. While some of these data are disconcerting, when viewed in another light, there may be a modest silver lining. If this study had been conducted 15 years ago, undoubtedly the results would have been bleaker, with higher misdiagnosis rates and grossly inaccurate treatment recommendations. Yet, results such as these are entirely unacceptable and misdiagnosis rates such as those reported (together with inappropriate treatment recommendations) would not be tolerated in other disciplines of medicine. Potential solutions include a more integrated training model with other disciplines of medicine and psychology (and diverse continuing education experiences) that buttress academic learning with applied clinical experience, as well as further advocacy efforts that seek to educate physicians and other health providers across a range of disciplines.

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