Obsessive–Compulsive Disorder in African American Children and Adolescents: Risks, Resiliency, and Barriers to Treatment

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Obsessive–compulsive disorder (OCD) is a serious condition that remains understudied in ethnorracial minority populations. The presence of OCD and the individual, familial, and cultural factors that influence this condition can interfere with healthy development and cause lifelong disability. To date, there has not been a single published research article focused on OCD in African American youth. Ethnic and racial minorities with OCD are underrepresented or altogether absent from treatment centers and research studies, although evidence suggests that OCD may be particularly persistent in these populations. This article reviews risk factors, protective factors, and barriers to treatment in African American children and adolescents with OCD. This review conceptualizes cultural differences in symptomology, low income, reduced access to care, racism, and mental health stigma, as risk factors. Also discussed are the roles of family factors in the development and maintenance of the disorder, including family accommodations, conflictual family communication, and parenting styles. Potential protective factors are also examined, including a positive ethnic identity, social support, present-centered time orientation, and religious communities. Implications of findings are discussed. There is an urgent need for research to understand the needs of African American children and adolescents with OCD.

Obsessive–compulsive disorder (OCD) is a severe illness and a major cause of disability worldwide, with a global burden comparable to that of schizophrenia (Ayuso-Mateos, 2007; Zohar, Fostick, Black, & Lopez-Ibor, 2007). OCD is highly disabling, with nearly two thirds of those afflicted reporting severe role impairment (Ruscio, Stein, Chiu, & Kessler, 2010) and much higher rates of unemployment compared to the general population (22% vs. 6%; Koran, Thienemann, & Kessler, 2010) and much higher rates of unemployment compared to the general population (22% vs. 6%; Koran, Thienemann, & Davenport, 1996). A vast majority of those with OCD have comorbid mental disorders (90%), with 40.7% also experiencing major depressive disorder and 38.6% also experiencing a comorbid substance use disorder (Ruscio et al., 2010).

The average age of onset is 19.5 years (Ruscio et al., 2010), and childhood onset is common (Fogel, 2003). By late adolescence, OCD has a lifetime prevalence rate of 2%–3% (Zohar, 1999), which translates to 1,000,000 afflicted youth ages 10–19. Childhood OCD is associated with high rates of comorbid disruptive, tic, and developmental disorders, as well as major depressive disorder (62%) and separation anxiety (35%; Geller, 2006). In addition to higher rates of comorbidity, early onset of OCD may result in higher severity of symptoms as an adult than a later onset (Butwicka & Gmitrowicz, 2010; Lomax, Oldfield, & Salkovskis, 2009), and even those who are successfully treated in childhood may still have impairments as adults in areas such as social functioning (Thomsen, 1995).

African Americans of All Ages Remain Undertreated for OCD

OCD is undertreated in African Americans of all ages (Williams, Sawyer, et al., 2015). The DSM–IV field trial, one of the largest studies of OCD conducted, drew from adult patients in OCD specialty clinics at five urban sites. However, out of 454 participants, only 2.8% were African Americans (Foa et al., 1995). In a large study of OCD (n = 257) that recruited both adults and children from multiple clinical treatment settings throughout New England—including inpatient admissions to a private psychiatric hospital and several large outpatient sites—95% were non-Hispanic White/European American (Mancebo et al., 2008). In a large study examining admissions data from 924 children or adult patients with OCD at Rogers Memorial Hospital, from 1999–2012 the overwhelming majority of patients were found to be non-Hispanic White (93.3%; Williams, Sawyer, et al., 2015). Only 1.2% were African American, and of these only two were children (ages 8–12). In fact, out of the 203 teens admitted to the Adolescent OCD Residential treatment center at Rogers Memorial Hospital, not one was African American. Furthermore, ethnic minorities required significantly longer stays, despite no differences in

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mean OCD severity pre- or posttreatment. The low number of African Americans being treated at these specialty clinics and associated findings supports the epidemiological finding that these groups are less likely to receive help for OCD (also see Fernández de la Cruz, Llorens, et al., 2015).

Himle et al. (2008) conducted the only epidemiological study of OCD in adult Black Americans (which included African Americans and Caribbean Americans), using data from the National Survey of American Life (NSAL)—the most comprehensive study of mental health disorders in Black Americans to date (Jackson et al., 2004). Comparing NSAL findings to the National Comorbidity Study Replication (NCS-R), for people with the most severe OCD, 93% of Americans receive some type of treatment whereas this was true for only 60% for African Americans (Himle et al., 2008; Ruscio et al., 2010). Additionally, traditionally African Americans with OCD completed less schooling in comparison to their unaffected counterparts (Bach et al., 2012). Himle et al. (2008) concluded that high levels of overall mental illness comorbidity and severity, limited access to state-of-the-art treatments, or reduced responses to currently available OCD treatments, which have not been well tested in the African American population, may all contribute to the high OCD persistence. (p. 999)

Thus African Americans are more likely to experience lifelong disability as a result of this treatable disorder.

Differences in mental health care use are not because of decreased needs. One epidemiological study found that African American young adolescents experienced a greatly increased risk of developing OCD compared to their European American counterparts (OR = 23.4; Valleni-Basile et al., 1994). Additionally, the National Household Survey on Drug Abuse (NHSDA) epidemiological study examined mental health conditions among diverse 12–17 year-olds (n = 19,430) via in-home surveys to determine 12-month prevalence and comorbidity of various mental disorders (Chen, Killewa-Jones, & Vega, 2005). For overall mental health, African Americans reported more symptoms, and, for OCD specifically, they reported twice the levels compared to non-Hispanic Whites. These findings are quite disparate, which may be due in part to measurement issues, as many epidemiological studies use computer-assisted programs to determine diagnoses and not expert clinicians. Several self-report measures of OCD are not valid for African American adults due to cultural differences in cleaning, grooming, and related attitudes that overlap with common OCD symptoms (Williams, Wetterneck, & Sawyer, 2015). Such validity issues have been noted in at least one measure of OCD for children (Lund, Dennison, Ewing, & de Carvalho, 2011); so it is possible that the standard interviews used in such studies are not an effective means of determining an OCD diagnosis in African Americans. Preliminary data from one study found that the Structured Clinical Interview for the DSM–IV Axis I Disorders (SCID; First, Spitzer, Gibbon, & Williams, 2002) missed 33.8% of African Americans with OCD (Davis, Chasson, Combs, & Williams, 2013).

African Americans have similar utilization of mental health services from social service agencies and general physicians compared to European Americans, but receive significantly fewer services from mental health specialists (Alegria et al., 2002). This is problematic for disorders like OCD that require specialized treatment (i.e., exposure and response/ritual prevention, or Ex/RP) for the most effective response (National Institute for Health and Clinical Excellence [NICE], 2006; Williams, Powers, & Foa, 2012). March (2006) notes that “African American children, who appear to have the same chance of having OCD as European American children, are rarely seen in OCD clinics for reasons that we need to understand if we are going to do a better job of extending the benefits of the latest effective treatments to all children” (p. 45).

The Knowledge Gap

In sum, African American youth experience OCD at comparable or greater rates compared to European American youth and are less likely to receive treatment, but little else is known. Previous clinical studies of OCD have not recruited adequate numbers of ethnic minority participants to adequately expand our understanding of OCD in this demographic (Williams, Powers, Yun, & Foa, 2010). For example, the National Institute of Mental Health (NIMH)-funded Pediatric OCD Treatment Study (POTS, 2004), conducted at three academic centers across the United States (ages 7–17), was 94% European American, with only 4% African American inclusion (n = 4). The NIMH-funded POTS II study (Franklin et al., 2011) was 92.7% European Americans with only 2.4% African American inclusion (n = 3). And the subsequent NIMH-funded POTS junior study (Freeman et al., 2014), was 91% European Americans with only 1.6% African American inclusion (n = 2). These studies were conducted in cities with ample minority populations (e.g., Philadelphia, which is 44.3% African American), so this cannot be explained by simply a lack of eligible participants. Underrepresentation afflicts nearly all other studies for OCD as well. In a review examining this problem, it was found that among all North American clinical trials of OCD from 1989–2009 (n = 2,221), only 1.3% of participants were African American, with culturally deficient recruitment strategies (i.e., recruitment of primarily White convenience samples) hypothesized as a cause of underrepresentation (Williams, Powers, Yun, & Foa, 2010).

Genetic factors are the strongest established risk factor for OCD, with overall heritability estimated at 48%, based on European samples (Monzani, Rijssijk, Harris, & Mataix-Cols, 2014). The OCD Collaborative Genetics Association Study (OCGAS; Stewart et al., 2013) is a large multisite research study, funded by several federal and private grants, that includes over 20 research teams. This study is also part of the NIMH Human Genetics Initiative, the goal of which is to establish a national resource of clinical data and biomaterials from people with mental disorders. The project has recruited 2,901 individuals with OCD, as well as numerous family members of those afflicted. However to date the sample includes only 22 Black participants with OCD, which is less than one percent of all participants enrolled (NIMH Repository and Genomics Resource, 2014). The lack of meaningful numbers of African Americans in genetic studies like the OCGAS impedes our understanding of the pathogenesis of OCD and inhibits progress toward developing effective therapies and interventions for African American youth.

In the United States, about 42 million (14%) identify as Black or African American, alone or in combination with another racial group (U.S. Census Bureau, 2011), yet our knowledge of OCD in
this group is limited to a handful of case studies (e.g., Chambless & Williams, 1995), a study of adults from the NSAL (Himle et al., 2008, Himle, Taylor, & Chatters, 2012), one naturalistic study of Black adults at an urban clinic (Friedman et al., 2003), and recent findings from a study of African American adults with OCD at the University of Pennsylvania (Williams, Proeoto, Casiano, & Franklin, 2012). The latter investigation represented a major leap forward in understanding OCD in African American adults, but there are still no randomized clinical trials of OCD with adequate numbers of African Americans of any age (Williams et al., 2010). There are also no genetic or family studies of African Americans with OCD, and it is not known what symptom presentations are most common in African American youth. In our exhaustive examination of the literature, which has included an ongoing searches across multiple databases (PsycINFO, PubMed, Medline, ERIC) and article reference lists, we have not been able to locate a single empirical study focused on African American children or adolescents with OCD (DeLapp, Williams, Davis, & Sawyer, 2016). As a result, we know very little about how established models of OCD may apply to African American youth, or how familial and social factors may interact with ethnicity to create unique treatment and prevention needs.

The Funding Gap

In an effort by the National Institutes of Health (NIH) to ensure that ethnic and racial minorities are adequately represented in research studies, Congress passed the NIH Revitalization Act of 1993. This act, and the redefining of sampling regulations, was intended to encourage researchers to include minorities and women in representative numbers in all studies conducted or supported by the NIH (U.S. Department of Health and Human Services [USDHHS], 2002). The Act states “there is an ethical importance of ensuring that recruitment is conducted in a manner that is fair to women, men and persons from minority populations so that no group is unduly burdened and that no group is unduly benefited” (USDHHS, 2002, p. 3). In the same guideline, it is clarified that minority samples must be included in the study if “there is no clear-cut scientific evidence to rule out significant differences of clinical or public health importance among racial or ethnic groups or subgroups in relation to the effects of study variables” (USDHHS, 2002, p. 25). By 1994, the NIH had revised its policy to require that women and minorities be included, and by 1995 the NIH refused to fund any project that did include in their grant proposals strategies by which they would achieve diversity in their samples. Nonetheless, low minority inclusion in NIH-funded OCD research persists, and the problem for African Americans is arguably worsening if the POTS studies are any indication. There are no clear penalties for the failure of grant recipients to include minorities. Thus federal funds propagate OCD research that disproportionally enhances the knowledge base of one ethnoracial group to the exclusion of others, with no effective mechanism in place to remedy this problem. Thus we are in the early stages of understanding the findings presented in this review due to a lack of research that includes adequate representation of African American youth with OCD.

Sociocultural Constructs

The development and severity of OCD in African American youth may best be understood with a model that includes sociocultural constructs, as well as the traditional contributors, such as generalized psychological and biological vulnerabilities (see Figure 1). Barlow’s (2002) model appears on the left, with factors specific to African Americans incorporated in boxes on the right (in boldface). These boxes represent the sociocultural variables that may be salient to African American youth with OCD, although it is believed that these may be applied to other stigmatized minorities as well. We also summarize the main point in a related table (see Table 1). In the remainder of this article, we elaborate on these factors and synthesize findings based on available related research.

Barriers to Treatment

Differences in Symptoms and Phenomenology

OCD is a heterogeneous disorder, and it is important to accurately understand symptom presentations in the various afflicted groups (Williams, Mugno, Franklin, & Faber, 2013). Age and age of onset can affect symptom expression. For example, one European study found adolescents were more likely to have “miscellaneous” compulsions (Butwicka & Gmitrowicz, 2010)—the grab bag of assorted and less common compulsions grouped at the end of the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989). McKay and colleagues (2006) found that child-hood OCD was structurally different than findings among adults, noting that children’s worries are more likely to include magical ideation and obsessions are more likely to lead to idiosyncratic behaviors. Thus youth with OCD may be more likely to obsess over unusual fears, such as losing one’s personality, committing suicide, harm coming to parents, sexuality, and so forth. Furthermore, symptoms exhibited by younger children may differ from those seen in adolescents; for example, Selles, Storch, and Lewin (2014) found that older youth more likely to have symptoms involving sexuality and magical thinking.

OCD is frequently misdiagnosed both in primary care settings and among mental health professionals (Glazier, Calixte, Rothschild, & Pinto, 2013; Sussman, 2003), and cross-cultural research has noted differences in obsessional content and compulsions in international studies (Hatch, Friedman, & Paradis, 1996; Williams & Steever, 2015). Misdiagnosis or missed diagnosis may partially account for the lack of identified African American OCD patients (Friedman et al., 2003), thus knowledge of cultural differences is essential for clinicians working with this population. In a recent study of African American adults with OCD, racial differences included that participants were unusually fearful of animals, felt a stronger need to be perfectly understood, and used counting compulsions as a means to combat aggressive obsessions (Williams, Elstein, Buckner, Abelson, & Himle, 2012). In general, African Americans are more likely to be admitted as inpatients (Snowden, Hastings, & Alvidrez, 2009), and thus it is possible that African American youth with the most severe form of OCD, especially those with unusual obsessions or compulsions, may be misdiagnosed as psychotic (Hollander & Cohen, 1994; Ninan & Shelton,
African Americans may be at higher risk for this, as they tend to be overdiagnosed with schizophrenia (Gara et al., 2012). Increased washing and cleaning appears to be a cultural norm among African Americans (Williams & Turkheimer, 2007), and although this OCD presentation may be more readily identified by clinicians, within African American families contamination symptoms may go unnoticed for a longer period, leading to recognition only when the symptoms become unmanageable (Williams, Abramowitz, & Olatunji, 2012). Greater symptom severity is related to poorer treatment outcome (Hurley, Saxena, Rauch, Hoehn-Saric, & Taber, 2002), and a longer period of disability represents reduced educational and career achievement (Himle et al., 2008). Additionally, given the importance of religious faith within the African American community, African Americans may be reluctant to endorse obsessions pertaining to negative religious images or thoughts (Alvidrez, Snowden, & Kaiser, 2008; Chatters, Taylor, Bullard, & Jackson, 2009).

Anxiety surrounding racism, embodied in negative racial stereotypes, may also play a role in OCD symptomology. African Americans may overemphasize cleanliness to counteract historical negative stereotypes about being dirty (Olatunji, Tomarken, & Zhao, 2014; Williams & Turkheimer, 2007). Likewise, they may be especially hesitant to disclose sexual or aggressive obsessions for fears confirming stereotypes about being violent or sexually deviant (Devine, 1989). Additionally, African American adults reported a fear of being misunderstood more often than their European Americans counterparts (8.5% vs. 3.7%; Williams, Elstein, et al., 2012), which may relate to a fear of fulfilling the stereotype of appearing unintelligent. Fears of fulfilling stereotypes may result in resultant anxiety in medical encounters (Penner, Blair, Albrecht, & Dovidio, 2014), thereby preventing disclosure of symptoms. Thus, there may be many differences in symptom presentation that may be important targets for clinician and patient awareness and education, based on the experience of being a stigmatized minority.

**Low Income**

African Americans on average have lower incomes than European Americans, thus the financial burden of treatment for OCD is a barrier that disproportionally affects African Americans—although both groups cite cost as a significant barrier to care (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). African Americans are less likely to have health insurance (19.5% uninsured compared with European Americans at 10.4%; DeNavas-Walt, Woodruff, & Proctor, 2008). Furthermore, income can impact other factors related to treatment beyond simply the cost of care, such as transportation costs and the ability to take time off from work.
off work to take a child for treatment. Thus low income can be a real barrier, with a differential impact by race on families with an OCD-affected child or adolescent.

### Reduced Access to Treatment

Barriers to treatment may also be caused by reduced access to providers and lack of availability of services (Geller & March, 2012). Ex/RP is a type of cognitive behavior therapy (CBT) that has been shown to be the most effective treatment approach for OCD (NICE, 2006; Williams, Powers, & Foa, 2012), but many individuals do not have access to it because of a lack of therapists who use empirically supported treatments, particularly in rural areas (Taylor et al., 2003). Most clinicians do not receive training in Ex/RP or empirically supported treatments in general (Barlow, Levitt, & Bufka, 1999; Nakagawa et al., 2000), resulting in a lack of behavioral therapists who can effectively treat OCD, particularly for individuals without overt rituals or the more easily recognized symptoms. As a result, families may have difficulty locating qualified providers in their communities. In fact, in a prior study of African American adults with the disorder (Williams, Domanico, et al., 2012), 76.1% said they did not know where to find help, which was significantly greater than among European Americans with OCD (50.0%). It could be that there are fewer OCD treatment providers in community mental health clinics nearest to African American neighborhoods. For example, the state of Kentucky has only two small specialty clinics for the treatment of OCD and related disorders, and both are in affluent areas of Louisville.

### Racism

African Americans are more likely to experience racism than any other group (Chou, Asnaani, & Hofmann, 2012; Cokley, Hall-Clark, & Hicks, 2011), thus many have concerns about receiving inadequate treatment or experiencing a misdiagnosis due to discrimination. African Americans have a cultural memory of abuses such as the U.S. Public Health Service Syphilis Study at Tuskegee, which continues to affect medical decision-making (Gamble, 1997), and many have had actual experiences of racial inequality during encounters with medical professionals (Whaley, 2001). In the aforementioned study of barriers to treatment in African American adults with OCD, almost a quarter were concerned with racial inequality in treatment (Williams, Domanico, et al., 2012). Thus, fears of experiencing racism may affect the willingness of African American parents to seek treatment for their children (Aronson, Burgess, Phelan, & Juarez, 2013).

Additionally, several studies have established a link between perceived racism and mental health outcomes, including depression (Banks & Kohn-Wood, 2007; Chou et al., 2012), substance use (Blume, Lovato, Thyken, & Denny, 2012), and overall psychological distress (Chae, Lincoln, & Jackson, 2011; Pieterse, Todd, Neville, & Carter, 2012). Although, no studies have specifically examined the role of race in the development of OCD, racial stressors could worsen the disorder in the same way other stressors can exacerbate symptoms (Rosso, Albert, Asinari, Bogetto, & Maina, 2012). The experience of racism may uniquely influence the expression of symptoms, as previously described (Williams, Elstein et al., 2012), and race based trauma could even be a catalyst for the onset of OCD in those who are predisposed to the disorder (Cromer, Schmidt, & Murphy, 2007).
Mental Health Stigma and Attitudes

Due in part to experiences of racism, African Americans are more likely to have negative beliefs about mental health care (USDHHS, 1999). African American consumers tend to believe mental health care is generally designed for European Americans and may view the typical psychologist as an older White male that does not understand economic or social difficulties in their lives (Alvidrez et al., 2008; Thompson, Bazile, & Akbar, 2004). They may seek treatment from a primary care physician for “nerve” problems when a mental health professional is a more appropriate option, and such practices may represent a cultural barrier to the most effective treatment (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). Additionally, African Americans may be more likely to seek out informal sources of support for emotional distress, such as a friend, family member, or pastor (Chatters et al., 2011; Woodward et al., 2008).

Finally, African American families may have a greater lack of knowledge about the disorder and/or struggle with placing the importance of mental health care in context of the face of other competing priorities. Among African American adults with the disorder, many prefer to handle the problem on their own, without involving a mental health professional (Williams, Domanico, et al., 2012). These preferences could likewise result in a barrier to treatment for youth afflicted with OCD as well.

Family Factors

Family Impact and Parenting Style

It is not known exactly how OCD impacts African American families with an afflicted child, although it is likely detrimental. In the following sections we discuss family accommodations, parenting styles, and family communication among African American youth with OCD. These are shown in Figure 1, with some as hypothesized risk factors and other believed to be protective.

High levels of distress and disrupted family functioning are the norm among families of youth with OCD, with estimates ranging from 60%–90% of families affected (Piacentini, Bergman, Keller, & McCracken, 2003; Renshaw, Steketee, & Chambless, 2005). Difficulties may persist into adulthood as up to 65% of family members of adults with OCD report at least moderate distress (Albert et al., 2010). OCD symptoms in youth may produce problems in other domains of family life as well. Piacentini et al. (2003) found that children and adolescents with OCD, as well as their parents, reported significant problems completing tasks at home that require concentration (e.g., reading, watching TV), and out of the home where parents may not be present (e.g., getting to class, eating in public places, being with a group of strangers). Thus, childhood OCD may damage family relationships and impair functioning not only in the child, but also in the family as a whole.

Child and adolescent OCD can negatively impact parent–child relationships. Parental involvement in rituals is linked to more severe child OCD symptoms, and family accommodation of compulsions and avoidance is related to poor family organization and parental hostility (Peris, Benazon, et al., 2008). Lebowitz, Vitulano, and Omer (2011) found that the afflicted children in these families engage in coercive behaviors related to their OCD, including rules forcefully imposed on parents and other family members. These demands for accommodation are more severe among children with externalizing symptoms, such as disruptive behaviors and rage outbursts, resulting in even greater difficulties for the most challenged families (Wu, Lewin, Murphy, Gefkjen, & Storch, 2014).

Parenting style has been found to play an important role in OCD severity. Peris, Bergman, et al. (2008) studied parental accommodation in 65 predominantly European American children and adolescents, and found that 46% of parents often participate in rituals, a practice that perpetuates symptoms (Calvocoressi et al., 1995). Parental psychopathology (esp., OCD), low family cohesion and organization, and greater severity of OCD symptoms in children were particularly associated with accommodation.

Parenting styles may be differentially effective in different ethnic groups. Most notably, authoritarian parenting has been consistently linked to problem behaviors in European American families but not African American families (Baumrind, 1972; Goodman et al., 1998; McLeod Druttschnitt, & Dornfeld, 1994; Peters, 1988). Whereas European American children appear to resist parental control attempts due to perceptions of intrusive parenting, high parental control in African American families may be viewed positively by children since more environmental stressors may be present, such as violence and racism, and this control may be perceived as protection against potential harm (Lamborn, Dornbusch, & Steinberg, 1996). McCabe and Clark (1999) found that among urban African American youth, parental demandingness was negatively associated with child acting out behaviors. Furthermore, Smetana, Crean, and Daddis (2002) found that in African Americans, adolescents who rated parents as high in behavioral control, and whose parent–child dyad was rated as positive in communication, displayed lower levels of problem behaviors. Mandara and Murray (2002) found that African American adolescents in the cohesive-authoritative family type had higher self-esteem than adolescents in both the defensive–negrulcent and conflicitive–authoritarian family types. Therefore, sociocultural factors appear to influence the perception of parenting behaviors deemed as functional, adaptive, and necessary for family functioning in minorities, which may differ from the perceptions of European Americans families.

African American adults may be less likely to accommodate OCD-related demands by children, as this would contradict cultural expectations for respect and obedience. Given that greater accommodation is correlated to higher symptom severity, refusal to accommodate and discouragement of rituals would be expected to result in decreased OCD severity (or at the very least, not worsen it). Furthermore, OCD-afflicted children are more likely to view these controlling parenting styles as a form of caring rather than intrusion, thus we predict that an authoritarian style is a protective factor in African American youth with OCD. However, it is possible that African American families may be more likely to accommodate in order to maintain family cohesion, which tends to be of greater importance in collectivistic cultural groups. Clearly, focused research that can provide a better understanding of what type of parenting style is most effective in African American youth with OCD would help clinicians better assist families, as appropriate interventions may differ by ethnic group.
Family Communication

It has been speculated that dysfunctional family communication patterns can contribute to the development of OCD. For example, O’Connor (2008) theorizes that people with OCD had worrisome tendencies as children, who had their worries shaped into obsessive thoughts or behaviors by parents. He also speculates that early childhood interpersonal familial experiences play a key role in the etiology and maintenance of OCD. Furthermore, in a family focused CBT treatment study of primarily European American children, Peris and colleagues (2012) found that family conflict and lack of cohesion were significantly correlated to poorer outcomes posttreatment.

In one of the few empirical studies of this issue, Sawyer, Williams, Chasson, Davis, and Chapman (2015) studied the relationship between family communication patterns and the development of psychopathology in two samples of African American adults, based on retrospective reports of family communication styles in childhood. African American adults who remembered having childhoods characterized by conflictual family communication were more likely to have depression and anxiety in adulthood, but interestingly there was no relationship between conflictual communication in childhood and OCD in adulthood. This finding supports the growing literature base that implicates biological processes as having primacy in the development OCD (e.g., Monzani et al., 2014), although it seems likely that disordered communication could be an impediment to effective treatment, if not a contributing factor to the development of the disorder. Research focused on family communication styles in African American families is needed to clarify these issues and their role in the development, severity, and maintenance of OCD.

Resiliency: Protective Factors

Ethnic Identity and Racial Socialization

Ethnic identity can impact psychopathology among African Americans (Nebblet, Banks, Cooper, & Smalls-Glover, 2013). Ethnic identity consists of a sense of commitment and belonging to an ethnic group, positive feelings about the group, and behaviors that indicate involvement within the group (Avery, Tonidandel, Thomas, Johnson, & Mack, 2007; Phinney, 1992; Roberts et al., 1999). Positive ethnic and racial identities are essential to the personal and collective well-being and resiliency of African American youth (American Psychological Association [APA] Task Force on Resilience and Strength in Black Children and Adolescents, 2008). Negative perceptions about one’s ethnoracial identity in African Americans has been linked to negative psychosocial, academic, and health risk outcomes (Rivas-Drake et al., 2014). For example, a study conducted with at-risk African American juveniles found that elevated OCD symptoms were correlated with a racial identity profile characterized by self-hatred and conflicted attitudes about being Black (Worrell, Andretta, & Woodland, 2014).

Ethnic identity is largely a product of racial socialization, with a strong, positive ethnic identity emerging as a protective factor against depression and anxiety among African Americans (Sellers, Caldwell, Schmeekle-Cone, & Zimmerman, 2003; Williams, Chapman, Wong, & Turkheimer, 2012). African American children who discover that others think negatively of them but can contextualize this in light of values, beliefs, and knowledge of a positive ethnic identity are more likely to be resilient in adverse conditions (APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008). Elmore and Gaylord-Harden (2013) found that parents who incorporate positive racial socialization messages into their parenting style report positive psychosocial and behavioral functioning in their children. One important area of future study should be the role of ethnic identity among youth with OCD and how this can be effectively incorporated into empirically supported treatments. Considering the importance of this construct in African Americans in general, clinicians should encourage and support youth in the exploration and promotion of their ethnoracial identities to help improve psychological well-being in African Americans suffering from the sequela of OCD (Williams, Chapman, Buckner, & Durrett, 2016).

Social Support

Family support has been found to be a protective factor for African American families. McCabe and Clark (1999) examined family protective factors among urban African American youth and found that kin support was negatively associated with acting out and shy or anxious behaviors in African American children. Further, kin support from extended family members decreased the negative effect of family stress on symptoms. The authors concluded that warmth from both immediate and extended family members may play integral roles in preventing anxiety and depression in African American youth.

Peer relationships may suffer in youth with OCD. Valderhaug and Ivarsson (2005) found that European adolescents reported more social and school related impairments compared to children without OCD. In a preliminary study of quality of life among African Americans adults with OCD from the NSAL dataset, those with OCD felt significantly less close to friends in comparison to African Americans with other anxiety disorders and unaffected individuals (Bach et al., 2012). One large study in London found that ethnic minority youth receiving treatment for OCD had more peer relationship problems reported by parents compared to White British youth with OCD (Fernández de la Cruz, Jassi, et al., 2015). If this pattern of disordered interpersonal functioning also occurs in African American youth with OCD, it would translate to profound feelings of isolation and alienation, compounding existing marginalization due to minority status with the effects of the OCD. This impairment could be particularly devastating in youth, who are still struggling to develop identities. In light of such difficulties, research is needed to determine how to improve social supports among youth with OCD.

Time Orientation

Time orientation, defined as one’s tendency to focus on the past, present, or future, varies by culture—although no individual or culture will exclusively consider only one of these to the exclusion of the others (Briley, 2009). The Eurocentric cultural
perspective tends to be future oriented. This can be viewed in its societal emphases, such as saving for retirement or the emphasis on preventive medicine and enthusiasm for new drugs and medical technologies. African Americans, however, tend to have more of a present time orientation (Akbar, 1991; Rubin & Belgrave, 1999). Those with a present time orientation are less likely to plan for the future as their cultures focus on events unfolding in the present, especially when there is a need to prioritize daily survival.

Previous research found that a stronger ethnic identity was associated with lower levels of anxiety and depression in African Americans but not for European Americans participants (Williams, Chapman, Wong, & Turkheimer, 2012). This was attributed in part to differences in Afrocentric versus Eurocentric worldviews surrounding time orientation. Anxiety is characterized as an attentive bias toward future possible threat over present moment experiences, and many interventions for anxiety disorders, in fact, relieve anxiety by teaching patients to shift their focus to the present (Borkovec, 2002). Therefore, cultural tendencies toward future events could predispose European Americans youth to experience greater anxiety associated with OCD and African Americans to experience less. Correspondingly, characterizing obsessions in OCD as “anxiety” may result in missing cultural differences in the experience of this core symptom. This underscores the importance of research focused on the phenomenology and experience of OCD in African American youth.

Religious Coping

Despite decreasing involvement in organized religion, the majority of Americans report some type of religious identification or spiritual beliefs (80% among European Americans and 87% of African Americans; Kosmin & Keysar, 2009). As faith plays an important role in the lives of people of all ages (Kosmin & Keysar, 2009), it is not surprising that high numbers of young OCD patients experience religious obsessions (30% in primarily European American treatment-seeking samples; Stewart et al., 2007). Religious obsessions include excessive worries about dying and not going to heaven, offending God, Satan, being sinful, perfectionism, and feeling the need to do what is always morally right.

African American families have historically relied heavily on spirituality and faith in the face of adversity and oppression (Boyd-Franklin, 2003; McCabe & Clark, 1999), but when OCD concerns are intertwined with religious beliefs, it can interfere with this important means of coping and identity, resulting in severe distress and feelings of alienation (Himle et al., 2012). One study of religion among African American adults with OCD found decreased involvement in formal religious activities (an important avenue for social support), due at least in part to OCD symptoms, and greater use of prayer and informal forms of spirituality (Himle et al., 2012). Thus, although religious coping may be protective for African Americans in general, when religious OCD obsessions take hold it can become detrimental, and the experience of OCD may prevent African Americans with the disorder from full participation in religious activities.

Conclusion

OCD is a highly debilitating disorder, and African American youth experience OCD in similar if not higher rates than European Americans, but they are underrepresented in research studies and at OCD treatments centers. As summarized in Table 1 and illustrated in Figure 1, there are multiple sociocultural factors that are believed to impact the expression of the disorder. Symptoms in African American youth may manifest differently when compared to European Americans, leading to a missed diagnosis or misdiagnosis. They also have less access to effective treatment resources.

African Americans may be distrustful of treatment because of past experiences of racial stigma and cultural stigma surrounding mental disorders (Thompson, Bazile, & Akbar, 2004; Woodward, 2011). As a result, they may instead seek treatment from nonmedical sources, such as friends, family, and the local church (Chatters, Taylor, Jackson, & Lincoln, 2008). In order to mitigate fears of racism, the mental health community needs continued training on how to engage African American families in culturally informed and sensitive ways (Terwilliger Bach, Bryan, & Williams, 2013).

Positive ethnic identity is embedded into African American culture and could be one means of resiliency in the face of OCD. Likewise, authoritarian parenting styles may buffer against OCD because parents are less likely than European Americans to accommodate children’s rituals. However, other traditional ways of coping with life stressors such as religion may not offer its usual protection, as certain forms of OCD latch onto important life domains, as many struggle with religious obsessions. Additionally, ethnic minority youth with OCD may be even more affected than their White counterparts in peer relations (i.e., Fernández de la Cruz, Jassi, Krebs, Clark, & Mataix-Cols, 2015), leading to isolation and alienation.

Future Directions

Not a single empirical study has been published with a focus on African American children or adolescents with OCD, and thus much work will be needed to validate our proposed sociocultural model of OCD in African American youth. Research should explore how barriers such as ethnic minority status, lack of resources, stigma, and culture affect young people with OCD, and how mental health relates to other important areas of functioning (e.g., quality of life).

Additionally, new research is needed to understand the genetics, phenomenology, and measurement of OCD in African American children and adolescents. As noted, OCD is a heterogeneous disorder, and as our understanding of this condition expands, it is clear that there are no bright lines demarking specific diagnoses. The new Obsessive–Compulsive and Related Disorders category in the DSM–5 encompasses many disorders that are thought to be related to OCD, such as body dysmorphic disorder, but a comorbidity study in African American adults found no relationship between OCD and several putatively related conditions (Williams, Brown, & Sawyer, 2016). Other disorders, such as illness anxiety and eating disorders, also share important features with OCD, and research into these areas is lacking as well. Thus, understanding...
general risk factors for all these conditions in African American youth is a critical endeavor, and much work remains to be done.

**Keywords:** African Americans; obsessive–compulsive disorder; children; adolescents

**References**


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