Several conditions in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association [APA], 2013) are classified as Obsessive-Compulsive and Related Disorder (OCRDs), including obsessive-compulsive disorder (OCD), hoarding disorder, excoriation disorder (skin picking), body dysmorphic disorder (BDD), and trichotillomania (TTM). OCRDs are characterized by compulsive and often repetitive behaviors. People suffering from OCRDs may experience high levels of distress, decreased quality of life, and symptoms may consume many hours per day (Flessner & Woods, 2006; Hajcak, Franklin, Simons, & Keuthen, 2006; Ruscio, Stein, Chiu, & Kessler, 2010).

Due to the low number of ethnic and racial minorities with OCRDs included in research studies, relatively little is known about these disorders in these groups (e.g., Williams, Powers, Yun, & Foa, 2010). One reason for this academic disparity is that ethnoracial minorities are largely absent from specialty treatment centers, which is a major source of participants in OCRDs research studies (e.g., Williams et al., 2010; Williams et al., 2015). There is a modest body of research on OCD in ethnoracial minorities, but relatively less on TTM and BDD, and virtually none on hoarding disorder and skin picking.

In the United States, the government defines African Americans, Asian Americans, and Native Americans as racial minorities, although people from these groups are also ethnic minorities because each group has their own distinct culture. Hispanic Americans and Arab Americans, also discussed here, are considered ethnic but not racial minority groups. We use the term “ethnoracial” minority to include both facets of cultural identity. Ethnoracial minorities tend to underutilize mental health treatment (Snowden & Cheung, 1990), which suggests varying cultural attitudes toward mental health among minority populations, as well as a negative social stigma. The current chapter is a review of attitudes, stigma, and barriers associated with
mental health treatment, as well as implications for clinical practice, among five ethnoracial minority groups in the United States.

Cultural Considerations in African Americans

Attitudes about Mental Health

In the United States, about 42 million (14%) identify as Black or African American, alone or in combination with another racial group (US Census Bureau, 2011a). Compared with non-Hispanic Whites, African Americans tend to have more negative attitudes about mental illness. For example, Williams, Beckmann-Mendez, and Turkheimer (2013) conducted a qualitative study involving in-depth interviews of six African Americans who participated in an OCD research study, and participants expressed concerns related to how others may view those with symptoms of a mental disorder. Concerns expressed by participants varied, but negative social consequences of disclosing mental illness and cultural mistrust were primary underlying themes. Concern that others may view such disclosures negatively suggests that within this population there may be unfavorable attitudes toward mental illness overall. Cultural mistrust may also alter the perception of mental illness, as mistrust of mental health professionals may make it difficult to consider mental illness a legitimate problem. Masuda, Anderson, and Edmonds (2012) also found that African American college students endorsed a negative perception of mental illness, and that this was an integral part of how they viewed mental health overall. The researchers reported that mental health stigma was strongly associated with help-seeking attitudes, and that participants endorsed the importance of self-concealment of personal information (Masuda et al., 2012).

African Americans tend to underutilize health care services, citing fears of mistreatment, being hospitalized involuntarily, or being used as “guinea pigs” (Ayalon & Alvidrez, 2007). African American consumers believe mental health care is generally designed for non-Hispanic Whites (Alvidrez, Snowden, & Kaiser, 2008), and African Americans tend to view the typical psychologist as an older White male that does not understand economic or social difficulties in their lives (Thompson, Bazile, & Akbar, 2004). Thus, African Americans may have a more difficult time trusting their therapists, and also view mental health settings negatively. They may prefer informal sources of emotional support, such as the local church, barbershop, beautician, or community elders. This appears to be particularly true for African Americans with larger family networks, working individuals, those experiencing greater discrimination, and men (Woodward, 2011; Woodward et al., 2008).

Although some research indicates more favorable opinions about mental health care compared with non-Hispanic White consumers prior to receiving services, these same studies find less satisfaction after services have begun and higher drop-out rates (Diala et al., 2000). Professionals in the medical and mental health fields may perpetuate such outcomes by failing to consider the historical perspective of patients that may be perpetuating negative perceptions of healthcare (Suite, La Bril, Primm, & Harrison-Ross, 2007), as well as prior experiences of discrimination in other settings. This may explain why African Americans may be less likely to see symptom reduction in treatment utilizing empirically supported interventions (i.e., Pole, Gone,
Kulkarni, 2008). Mistrust of psychotherapy within this population may interfere with positive therapeutic outcomes in ways that non-Hispanic Whites may not experience (Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

Stigma and Shame

Pervasive negative stereotypes contribute to a sense of stigma and shame in African Americans. Williams, Gooden, and Davis (2012c) outlined the harmful effects of pathological stereotypes, which include notions such as lazy, poor, unintelligent, and sexually predatory/deviant. Pathological stereotyping perpetuates the idea that the target group does not have desirable characteristics, which in turn provides justification for unfair treatment by others.

Stereotypes may also play a role in OCD symptomology, as African Americans may over endorse symptoms pertaining to cleanliness to counteract historical negative stereotypes about being dirty (Devine, 1989; Williams & Turkheimer, 2007). Likewise, they may be hesitant to disclose sexual or aggressive obsessions for fears confirming stereotypes about being violent or sexually deviant. Furthermore, given the importance of religious faith within the African American community (Alvidrez et al., 2008), African Americans with OCD may be reluctant to endorse obsessions pertaining to negative religious images or thoughts (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012a).

In African American communities, hair has a cultural history with a host of social and emotional implications. In its natural state, most African American hair is tightly curled, however, in American culture, longer straighter hair is the Eurocentric female ideal. As a result, African American women may have conflicted feelings about their hair and devote a great deal of time to its care. Thus, African American women with TTM are more likely to confide in their hairdressers than seek mental health care for the resulting hair loss (Neal-Barnett, Ward-Brown, Mitchell, & Krownapple, 2000). Conversely, African American women tend to have a more positive image with regard to body shape, which may be somewhat protective against problems such as BDD (e.g., Marques et al., 2011a).

Barriers to Treatment

Other than stigma and negative cultural attitudes toward mental health care, there may also be additional barriers African Americans encounter when seeking treatment for OCRDs. In the aforementioned study by Williams and colleagues (2012a), 22.5% of African Americans with OCD endorsed clinician concerns related to unfair treatment due to race or ethnicity compared with only 7.4% of White participants. It was found that 38.0% of African American participants were uncomfortable discussing their problems with a professional compared with 25.9% of White participants. Additionally, African Americans (8.5%) reported a fear of being misunderstood more often than their White counterparts (3.7%) (Williams, Elstein, Buckner, Abelson, & Himle, 2012b), which may relate to a fear of being perceived as unintelligent.

Additional concerns endorsed by African Americans investigated by Williams et al. (2012a) included financial burden (56.3%) and access to treatment (76.1%). The authors found that the most and least wealthy subjects were not concerned about
cost, confident they could receive help through public or private insurance providers. Participants most concerned had incomes low enough to not have access to private insurance, and too high to qualify for public services. Furthermore, African Americans prefer to have an ethnically matched clinician (Malat, Purcell, & van Ryn, 2010), which could present as a significant barrier, as African Americans make up only about 5% of psychologists (US Bureau of Labor Statistics, 2012).

Misdiagnosis may also be a significant barrier to treatment, as African Americans may have differences in symptom presentation compared with non-Hispanic Whites. In addition to differences in presentation, some subtypes of OCD are more often misdiagnosed overall. For example, in a case study, an African American man presented with scrupulous thoughts that he was responsible for the murder of a stranger and that Satan was placing impure thoughts into his mind. In order to neutralize this, he would read the Bible for several hours or repeat “I reject these thoughts” several times a day (Ninan & Shelton, 1993). Although this behavior was typical of the OCD symptom dimension characterized by unacceptable thoughts, clinicians unfamiliar with OCD may not recognize it as readily as a more common symptom dimension, such as contamination (Glazier, Calixte, Rothschild, & Pinto, 2013; Williams et al., 2014).

In addition to misdiagnosis of disorders like OCD, African Americans are consistently overdiagnosed with psychosis (Whaley & Hall, 2009), which may be due to treatment providers’ acceptance of pathological stereotypes, resulting in a more severe diagnosis. In the previously mentioned case study by Ninan and Shelton (1993) the man was misdiagnosed with psychosis at an outpatient clinic when it was fairly clear that he was experiencing obsessions and using compulsions to reduce his anxiety. Unsurprisingly, the neuroleptics he was prescribed were not effective, and the man was referred for inpatient treatment. Upon reexamination, his diagnosis was changed to OCD and his treatment and medication were altered to focus on his OCD symptoms. His symptoms subsided over the next three weeks, lending evidence to his OCD diagnosis being correct.

Help-seeking for OCRDs

When considering help-seeking behavior, Himle and colleagues (2008) analyzed data from the National Survey of American Life (NSAL) (African Americans N=3,570), and found that when African Americans with OCD seek help for mental disorders, they tend to employ general medical professionals (22.8%), human services (21.5%), mental health specialists (20.7%), SRI medication (19.9%), or contemporary alternatives (5.1%). Corroborating the main avenue of help as a medical option, Friedman, Hatch, and Paradis (1993) investigated help-seeking behaviors of African Americans in a dermatology clinic; results illustrated that 15% of subjects suffered from undiagnosed OCD, and 11% had panic disorder, posttraumatic stress disorder, or generalized anxiety disorder, suggesting that members of this community may seek medical help before mental health treatment.

Findings by Alvidrez and colleagues (2008) illustrate that African Americans may view the church as the most acceptable support system outside of their respective families, which is also consistent with research conducted by Chapman and Steger (2010), who found that African Americans used positive religious coping strategies for anxiety more often than non-Hispanic Whites. Himle, Taylor, and Chatters (2012) examined religion in African Americans with OCD and found religious coping to be positively
associated with OCD symptom severity. However, the researchers also found that frequent religious service attendance was negatively associated with OCD severity, as perhaps OC symptoms prevented suffers from attending services (Himle et al., 2012). Nonetheless, research such as this appears to be congruent with the idea that African Americans may value the church as an important avenue for treatment.

Cultural Adaptations to Treatment of OCRDs

There have not been many studies examining specific treatment issues in African Americans with OCRDs, however, Friedman and colleagues (2003) examined the efficacy of exposure and ritual prevention (Ex/RP) among a sample of African Americans, Caribbean Americans, and European Americans with OCD. Results showed that despite being asked about questions pertaining specifically to obsessions and compulsions, African Americans were more likely to report only symptoms of panic disorder and agoraphobia and conceal OCD symptoms. This is consistent with previous research by Hatch, Friedman, and Paradis (1996), suggesting that African Americans may be more secretive about OCD symptoms to clinicians. These patients were more likely to disclose their OC symptoms once a strong therapeutic alliance was formed, suggesting that good rapport may be particularly important for African Americans. Thus, clinicians should take more time to diagnose African American clients who report other anxiety symptoms, as problems like OCD may also be present. The authors also found that educating clients on the differences between positive and negative coping strategies was effective in helping them understand how their compulsions were maintaining negative symptomatology.

Individuals suffering from disorders in which appearance is prominent might benefit from an exploration of their own beliefs in these areas. A therapist might help the client articulate what sort of features they believe are ideal and assist the client in placing those beliefs within their proper sociocultural and historical context. For example, understanding the oppression inherent in the disparate social value placed on Whiteness and European features may help clients suffering from BDD better appreciate their African features (e.g., Weingarden et al., 2011). When working with stigmatized minorities, it is important for the therapist to validate the client’s experience (e.g., worse treatment from others due to racism), without validating distortions in thinking (e.g., brown skin makes one unattractive).

Hatch and colleagues (1996) investigated CBT treatment for anxiety in African Americans, and noted that they may be unwilling to disclose diagnoses to their family, families may be extremely tolerant of symptoms, and sufferers may be convinced they were or would become psychotic. These findings further illustrate the negative stigma attached to mental health within the African Americans community (i.e., Williams et al., 2013), making open discussion of emotional problems difficult, and potentially causing symptoms to be tolerated rather than be seen as problematic. Additionally, the fear of becoming psychotic may reflect a fear of being involuntarily hospitalized, consistent with research by Williams et al., (2013), where 29.6% of participants endorsed this fear, which is not completely unsupported by the research (Ninan & Shelton, 1993; Snowden, Hastings, & Alvidrez, 2009; Whaley & Hall, 2009).

Given these issues, it may be extremely useful to take extra time before treatment to not only thoroughly assess symptoms and parse out comorbid conditions, but to also educate African American clients about OCRDs, normalize the disorder, and
reduce stigma surrounding mental illness overall. Being transparent about what a specific diagnosis means for a client, as well as what treatment entails, will break down some barriers that have historically disproportionately impacted this population. By being open and direct about these disorders and the treatment process, it may also be easier for clinicians to establish strong rapport.

As African Americans with OCD are more likely to endorse prayer as being important during times of stress (Himle et al., 2012), and are more likely to function within an extended family structure (Ruggle, 1994), integrating concepts from these domains into psychotherapy may be useful. As such, discussing who among an African American client’s support network (i.e., church, family, God, etc.) may be a good source of strength and support throughout treatment may prove useful. Clinicians may also want to explore adopting an Afrocentric approach to treatment, highlighting faith, family support, resiliency, and optimism (Baldwin & Bell, 1985; Jackson & Sears, 1992).

Cultural Considerations in Hispanic/Latino Americans

Attitudes about Mental Health

In the United States, about 50.5 million (16%) are of Hispanic or Latino origin (US Census Bureau, 2011b). Similar to African Americans, Hispanic/Latino Americans tend to have a negative perception of mental illness, which may be due to cultural norms. For example, Nadeem and colleagues (2007) found that immigrant Latina and African American women were significantly more concerned about the negative stigma attached to mental health when compared with US-born non-Hispanic Whites. Additionally machismo and caballerismo may foster negative attitudes in Latino men. Machismo can be defined as hypermasculinity, domination of women, aggression, “hard drinking,” and other predominantly negative male behaviors (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). There is also the construct of caballerismo, which embodies positive male images of the nurturing provider that respects others, defends those that are weak, and lives by an ethical code of values that are chivalrous in nature (Arciniega et al., 2008). While these attitudes are culturally normative and seen as positive, they may foster negative attitudes toward mental health.

Hispanic/Latino individuals have been shown to have a more negative outlook toward psychotherapy than non-Hispanic White individuals. Specifically, Hispanic/Latino Americans have been found to endorse lower expectations regarding the therapist, therapeutic process, and self-improvement (Wetterneck, Little, Rinehart, Cervantes, & Burgess, 2010). Additionally, immigrant status heavily influences perceptions within the Hispanic/Latino community. Non-US-born Hispanic/Latino immigrants are less likely to utilize mental health or medical services overall (Chen & Vargas-Bustamante, 2011; Shattell, Hamilton, Starr, Jenkins, & Hindeliter, 2008), while nonimmigrant Latino individuals are more likely to utilize mental health services (Alegria et al., 2007). These findings highlight that Hispanic/Latino individuals residing in the United States are not one homogeneous group, with many different factors influencing their attitudes and adherence to cultural norms.

Considering the heterogeneity of these groups, different groups may have different experiences that may or may not impact their attitudes toward mental health care. For example, the US has been greatly involved in Puerto Rico’s politics, and, as a
result, some Puerto Ricans may resent the US and want independence, while others may appreciate US involvement (Altarriba & Bauer, 1998). These attitudes could potentially push these individuals to retain native values, and these values may not include mental health treatment (Altarriba & Bauer, 1998). Altarriba and Baurer (1998) also studied Cuban Americans that often migrated to the US between 1950 and 1980. They found that certain Cubans that entered the US were political exiles and/or severely mentally ill, which lead to an unfriendly atmosphere from those already living in the US (Boswell & Curtis, 1984; Suárez, 1993). So, the manner in which a particular population came to the US may impact their views on mental health overall, potentially producing cultural mistrust and a reluctance to endorse problems.

In addition, religious affiliation may impact attitudes toward mental health care in Hispanic/Latinos. Moreno and Cardemil (2013) examined help-seeking and religious behaviors among Latino Americans, and found that participants utilized coping methods for mental health problems that were consistent with their religious affiliation. Specifically, older adults preferred to use religious and spiritual methods to cope with adversity, and many preferred religious counseling services. The authors found that participants were most willing to seek services if they felt understood, were experiencing severe symptoms, or if the impairments were biological in origin. Additionally, participants who endorsed these reasons tended to have more education and were more acculturated. This study suggests that there may be a preference among the Latino population to cope with emotional difficulties through religious faith, but also highlights the effects of acculturation on attitudes toward mental health. Latino individuals who are more acculturated may have more positive attitudes toward mental health care, thereby being more comfortable seeking mental health services.

**Stigma and Shame**

When considering overall stigma and shame in Latino/Hispanic Americans, racial discrimination and stereotyping can produce negative outcomes. Specifically, Basáñez, Unger, Soto, Crano, and Baezconde-Garbanati (2013) investigated discrimination as a long-term risk factor for depressive symptoms among Hispanic American adolescents. They found that perceived discrimination experienced in the 9th grade predicted depressive symptoms and drug use in the 11th grade, even when controlling for socioeconomic status, generation status, and acculturation. Furthermore, Chou, Asnaani, and Hofmann (2012) investigated the harmful psychological effects of discrimination among three ethnic groups, and perceived discrimination was associated with endorsement major depressive disorder and panic disorder with agoraphobia among Hispanic American participants, even when controlling for socioeconomic status, education, age, and gender.

Given that racial discrimination is common among ethnic minorities in the US (Chou et al., 2012), this may be a concern when seeking mental health treatment, potentially producing a feeling of fear or shame. Coupled with this, Latino/Hispanic individuals may also feel stigma and shame towards having a mental illness. For example, Hampton and Sharpe (2014) found that Latino American students would feel more shameful if they had a mental disorder when compared with Asian American and non-Hispanic White students.
Furthermore, one large study comparing European American (N = 3,986) and Hispanic American (N = 473) adults found that Hispanics may have higher levels of interpersonal functioning and social support, but an OCD diagnosis was significantly related to problems with interpersonal functioning (Hernandez, Plant, Sachs-Ericsson, & Joiner, 2005). This may result in excessive enmeshment with family, which may be especially problematic among those in more collectivistic cultures.

Barriers to Treatment

Latinos are disproportionately disadvantaged in comparison to non-Hispanic Whites, with three times as many being uninsured (US Census Bureau, 2008), which makes obtaining specialty treatment difficult (Alegria et al., 2002). Language barriers may also pose a significant obstacle to adequate mental health treatment within the Latino population. For example, only 1% of psychologists in the US are of Latino/Hispanic descent and they may or may not speak Spanish (Vega et al., 2007).

In addition to financial and language barriers, there are services that Latino/Hispanic individuals may more typically pursue due to unique expression of mental health symptoms, which can potentially prevent them from receiving efficacious treatment for OCRDs. Specifically, past research indicates that symptom somatization is common within the Latino community and may increase the likelihood of misdiagnosis (Chavira et al., 2008; Fontenelle, Mendelowicz, Marques, & Versiani, 2004). As a result, they are more likely to seek medical treatments rather than mental health services (Alegria et al., 2007) and will be less likely to receive empirically supported treatment. Also, some of the standard treatments for disorders like OCD may not be as efficacious for somatic symptoms, which further decreases the likelihood of positive therapeutic outcomes (Wetterneck et al., 2012). Thus, evidenced-based treatments may not be appropriate in certain cultures, as these treatments were validated and developed for Westernized symptomatology, warranting the investigation of cultural adaptation to increase treatment efficacy.

A reluctance to endorse impairment among men in this population due to machismo and callaberismo ideology among Hispanic/Latino men may make treatment extremely difficult, and reduce treatment seeking behaviors. Saez, Casado, and Wade (2009) found that Hispanic/Latino men endorsing these attitudes were less likely to appreciate different attitudes and behaviors among other men. This may make psychotherapy difficult with men who may not endorse similar cultural values.

Help-seeking for OCRDs

Less than 9% of Hispanic Americans with a mental disorder contact a mental health professional and fewer than 20% of these seek help through a general health care provider. Of Hispanics in the US, 59% identify as Catholic, almost triple the percentage of European Americans (Kosmin & Keysar, 2009). Thus, the role of religion may differ for Hispanic/Latino Americans with OCRDs. Furthermore, individuals within this population are more likely to see a faith healer for health issues or turn to a family doctor, family, or friends for help instead of seeking a mental health professional (Altarriba & Bauer, 1998).
Cultural Adaptations to Treatment of OCRDs

Acculturation and social support should be considered when working with individuals that identify as Hispanic/Latino, and family tends to be a primary means of support (Gloria & Rodriguez, 2000). Considering family is often the informal outlet for mental health concerns within this community, clinicians should make an effort to integrate family into the treatment, perhaps by offering a few family therapy sessions or consulting with family members on how they can be helpful in the client’s treatment. Involving the family can improve treatment adherence and also bolster the therapeutic alliance. For example, a meta-analysis conducted by Thompson-Hollands, Edson, Thompson, and Comer (2014), suggested that family inclusive treatment for OCD was largely effective in reducing symptom severity and family accommodation, and this may be particularly salient for Hispanic Americans. Additionally, considering the strong focus on religion within this population, incorporating faith into empirically supported treatments may also be helpful for attaining positive therapeutic outcomes. However, assessing religious beliefs prior to treatment adaptation is essential, as Hispanic/Latino individuals differ in the importance of their religious beliefs.

Considering the machismo and callamberismo culture among Latino men, it may be helpful to educate clinicians on how to approach treatment in a manner that appeals to their masculine styles. For example, it may be more useful at first for male clinicians to treat such clients to bolster rapport. Furthermore, male clinicians could provide an alternative perspective on acceptable male behavior, such as disclosure and empathy. Male clinicians can educate male clients on the importance of addressing psychological concerns and appeal to their clients by affirming that psychological concerns does not make one weak.

A case study by Wetterneck, Williams, Tellawi, and Bruce (2016) outlines some cultural issues when treating OCD in Hispanic/Latino individual male. “Paul,” a 40-year-old Cuban American, experienced intrusive thoughts about committing suicide and was extremely concerned about how such an event would impact his family. His symptoms eventually subsided with cognitive behavioral therapy, but a few cultural barriers, consistent with difficulties within this population, arose to impede treatment. Specifically, Paul revealed that his childhood environment did not foster a willingness to express emotion or psychological impairments. His mother had many emotional outbursts, and even attempted suicide in front of him, but these incidents were not discussed. Paul’s childhood experiences led him to believe that he should not burden others by expressing emotion. Additionally, during treatment the importance of Paul’s social support network was discussed, and he revealed that he was having difficulties making friends, due in part to cultural barriers. Another significant barrier that arose was financial concerns surrounding treatment. Due to his financial situation, Paul almost opted not to receive treatment, and was uncomfortable accepting treatment at a reduced fee. If flexibility and understanding had not been shown by his clinicians he would not have completed treatment. Finances may be a significant barrier to Hispanic/Latino Americans, and financial flexibility should be practiced by mental health professionals when needed.

One study found that Hispanic Americans were similar to European Americans in all OCD symptom dimensions except scrupulous/religious concerns, in which the former had significantly higher severity ratings in a young adult, nonclinical sample.
(Tellawi et al., 2012). Similar to African Americans endorsing higher contamination concerns due to culturally normative behaviors, it may be normal for the Hispanic American community to endorse more scrupulous/religious concerns. Due to this, clinicians should carefully assess OC symptoms related to scrupulous/religious concerns in this population, as to not pathologize culturally normative behavior.

Although research is extremely limited, Neal-Barnett et al. (2010) assessed small sample of Latinos and African Americans with TTM and found that they experience less tension before hair pulling in comparison with their non-Hispanic White counterparts. Given that African Americans have been shown to experience anxiety prior to hair pulling (Mansueto, Thomas, & Brice, 2007; Neal-Barnett & Stadulis, 2006), the authors suggest that in future studies the word “tension” may need to be replaced with another affective descriptor, such as “uptight,” to better capture feelings of anxiety prior to hair pulling in ethnoracial minorities with TTM. Clinicians should also be sure to use more broad descriptors, as well as be cognizant of any language barriers that may influence reporting style and the assessment process. Further, like African Americans, cultural messages about hair may produce conflicted feelings about hair and cause them to devote excessive time to hair care. Therefore, Hispanic Americans with TTM may also be more likely to disclose to their hairdressers for concerns with hair loss, rather than seek out a mental health professional (Neal-Barnett et al., 2000).

When considering BDD in Hispanic/Latino individuals, there has not been much research assessing differences in stigma, attitudes, and help-seeking behaviors. However, in a study conducted by Marques and colleagues (2011a), the authors assessed BDD and body concern behaviors an ethnically diverse sample and found no differences between non-Hispanic Whites and Hispanic participants. However, studies investigating body image in Hispanic college students have yielded interesting findings. For example, Warren and Rios (2013) found that endorsement of Western media, social comparison with models, and acculturative stress were all positively associated with poor body image among Hispanic college students. Similarly, Menon and Harter (2012) found acculturative stress to be a predictor of poor body image in Hispanic undergraduates. However, social support significantly reduced poor body image and acculturative distress in this study. Taken together, clinicians should assess acculturative stress (e.g., Societal, Attitudinal, Familial, and Environmental Acculturative Stress Scale) (Mena, Padilla, & Maldonado, 1987) and social support as they relate to BDD when working with this population.

### Cultural Considerations in Asian Americans and Indian Americans

#### Attitudes about Mental Health

While Asian Americans are composed of very heterogeneous subgroups – including Chinese, Japanese, Cambodian, Vietnamese, Indian, etc. – many researchers have studied these populations together because of similar cultural views in comparison with their Western counterparts. However, there remain very distinct cultural and socioeconomic influences of the various subgroups that have a differential impact on mental health care attitudes and treatment-seeking that need to be explored further.
In the United States, 17.3 million people (5.6\% of the total population) identified as Asian, either alone or in combination with one or more other races (US Census Bureau, 2012). Previous work has suggested that Asian American and Indian American (AA/IA) individuals endorse negative attitudes toward mental illness, but many studies have used self-report measures, which can potentially elicit negative reactions as a result of pressure to disclose to experimenters (Gawronski & Bodenhausen, 2007; Strack & Deutsch, 2004). To better understand attitudes toward mental illness, Cheon and Chiao (2012) investigated implicit and explicit attitudes in AA/IA and non-Hispanic Whites. The authors found that AA/IA subjects endorsed more negative implicit attitudes toward mental illness, suggesting that despite public perception, AA/IA individuals may still endorse these attitudes implicitly. Furthermore, when examining explicit attitudes, the authors found that AA/IAs wanted a greater social distance from mental illness in comparison with non-Hispanic Whites, providing further evidence that AA/IA populations may not view mental illness favorably.

Within the AA/IA community, intellectualization and self-control are valued in comparison to open emotional expression, suggesting that individuals within these populations may be more likely to internalize mental health impairments as opposed to disclosing them to family, friends, and mental health professionals (Mysorekar, 2007; Ramisetty-Mikler, 1993). Thus, AA/IA individuals may not necessarily view mental health care in a negative way, but may prefer not to utilize mental health care services.

**Stigma and Shame**

Stereotypes about AA/IA individuals may serve as a source of distress, despite some stereotypes being considered desirable. Son and Shelton (2011) investigated the effects of positive stereotypes in Asian American college students and found that when they expected European American students to stereotype them as intelligent and successful academically, they felt more anxious and experienced internal pressure to change to fit in. Furthermore, Park, Schwartz, Lee, Kim, and Rodriguez (2013) found a positive association between perceived discrimination and antisocial behaviors, suggesting that experiences of discrimination may not only deter treatment seeking for fear of negative outcomes, but can make the treatment process difficult, as interacting with a person displaying antisocial behaviors may prove challenging.

However, negative stereotypes perpetuated within the AA/IA community can be a source of stigma and shame as well. In a study on BDD, Asian Americans reported more concern with straight hair and dark skin than their non-Hispanic White counterparts. The authors postulated that this may be due to concerns about being associated with negative stereotypes linked to the Asian American community (Marques et al., 2011a).

Members of the AA/IA population, like the Hispanic/Latino population, may be more likely to endorse somatic symptoms. However, this may be due to negative attitudes toward mental illness (Chu & Sue, 2011), and among these groups, the disclosure of emotional impairment or stress may be associated with feelings of isolation, guilt, and shame. Additionally, disclosure can potentially be seen as dishonoring the family/community or personal weakness (Gilbert, Gilbert, & Sanghera, 2004; Leong, Kim, & Gupta, 2011), making it potentially more difficult to seek or adhere to treatment.
Barriers to Treatment

AA/IAs tend to seek treatment less and have higher therapy dropout rates when compared to other groups (Leong et al., 2011), which may be due in part to system-related issues and socioeconomic barriers within the AA/IA community. Specifically, research suggests that Southeast Asian Americans have lower insurance coverage and are more likely to be afflicted by poverty, which may help to explain lower rates of psychological functioning relative to other Asian subgroups (Reeves & Bennett, 2004).

In addition to financial barriers, there is also an issue with availability of culturally and linguistically appropriate services for AA/IA individuals (Chandras, 1997). Members of these communities may be less familiar with counseling and psychotherapy as treatment options, and concerns that their cultural values may not be present in mental health treatment may serve as a deterrent. Language may be a significant barrier for AA/IA individuals as well, as the lack of linguistically appropriate mental health providers can make treatment seeking and the treatment process itself extremely difficult.

Misdiagnosis may also be a barrier to treatment within this population, as AA/IA individuals with OCRDs may experience symptoms influenced by culturally specific concerns. Holt, Phillips, Shapiro, and Becker (2003) conducted a case study outlining the treatment of an Asian American woman with comorbid OCD and BDD. The authors concluded that the patient’s BDD was intertwined with her cultural identity in that she was ashamed of her appearance due to American standards of beauty. Additionally, her parents were originally from China, where having one child is extremely common, and as the patient was an only child, she received significant positive and negative attention/pressure from her parents. The patient also reported difficulties adjusting socially upon moving to the US at age 10, which may have contributed to her feelings of inadequacy and symptom presentation. Furthermore, coping with sexual abuse from her family was even more difficult, given that her parents dismissed it quickly as Chinese culture endorses family honor. This particular case illustrated the importance of culture in a developmental and treatment context. Treatment without consideration of a client’s culturally specific family structure, beliefs, or upbringing may hinder the understanding of a client’s psychopathology, thereby making positive therapeutic outcomes more difficult to obtain.

Interestingly, research is mixed on the rate of treatment barriers within AA/IA populations. One study assessing individuals with BDD found that Asian Americans reported fewer treatment barriers due to stigma, shame, discrimination, and treatment perception and satisfaction compared with non-Hispanic Whites. While this contrasted the broad literature on treatment barriers in ethnic minorities, the authors hypothesized that this finding may have been due to Asian Americans’ preference for preserving one’s dignity and hide their embarrassment about their disorder or barriers (Marques, Weingarden, LeBlanc, & Wilheim, 2011b). This suggests the possibility that while overt treatment barriers may not be always present within this population, there still may be underlying shame and stigma driving treatment-seeking behavior that should be addressed.

Help-seeking for OCRDs

When considering help-seeking for emotional difficulties in AA/IA populations, sources of support often include friends, family, or attempting to work out problems alone until impairment becomes too severe to manage (Durvasula & Sue, 1996;
Narikiyo & Kameoka, 1992; Zhang, Snowden, & Sue, 1998). Treatment-seeking behaviors may include the tendency of AA/IA individuals to somaticize symptoms, as fatigue or weakness (Leong et al., 2011; Ramakrishna & Weiss, 1996), which could potentially mean that they may seek help from physicians more often than mental health professionals.

When considering perceptions of mental health in AA/IAs, religion may also play a major role. Specifically, Buddhism, Confucianism, and Hinduism each view the source of mental illness differently from Western conceptualizations. For example, IA individuals may be more likely to view illness as a result of bad karma, which is a reflection of the Hindu belief that the manifestation of illness is a result of wrongdoings one may have committed in the past (Chandiramani, Srivastava, & Patel, 2003). As a result, individuals following this particular religion may see mental illness as a deserved punishment, subsequently preventing help-seeking.

In addition to religious practices, delays in seeking appropriate mental health care may also be associated with culturally salient treatment preferences. In contrast to Westernized mental health, AA/IAs more often believe in the integration of spirit, body, and mind when addressing illness. As a result, members of this population may be likely to seek spiritual healing or mind–body treatments such as Ayurvedic or Chinese medicine in lieu of traditional Westernized mental health practices (Chu & Sue, 2011; Durvasula & Mylvaganam, 1994).

Cultural Adaptations to Treatment of OCRDs

Clinicians should be aware of the unique cultural views that AA/IAs have when approaching treatment for OCRDs. Given that AA/IAs perceive mental illness as stigmatizing and may be less likely to seek out mental health services until problems are quite severe, clinicians should be aware of the unique challenges that their clients will face. Additionally, given the importance of family honor within this population, clinicians should not only try to normalize the experience of mental illness, but also strive to integrate the family into the treatment process and attempt to educate and normalize the experience of mental illness within the family. Clinicians should be cognizant of other treatment approaches clients may want to utilize in addition to Westernized approaches, to provide comprehensive care that is both effective and culturally appropriate.

Cultural Considerations in Native Americans

Attitudes About Mental Health

There are about 4 million Native Americans (American Indians and Alaskan Natives) in the US (1.4% of the population), either alone or in combination with one or more other races (US Census Bureau, 2007). Among Native Americans, the concept of mental illness has different meanings and is interpreted in various ways. Thompson, Walker, and Silk-Walker (1993) found that Native American people view mental illness as a form of supernatural possession, imbalance, and disharmony with inner and outer natural forces, an expression of a special gift, a hopeless state, or terminal phase of an illness. Prior to European immersion, Native Americans did not conceptualize
mental illness as mental, but as a physical ailment or “soul loss” (Walker & Ladue, 1986). Some tribes even viewed symptoms of mental illness as deviant behavior and would punish the individual through tribal reprimanding or exclusion from certain community activities (Thompson, 1996).

There is a significant history of distrust between Native and European Americans as a result of spiritual, emotional, and physical mistreatment perpetuated historically against Native Americans. This distrust of Westernized or “White” medicine still exists today, and thus a Native American client may approach a non-Native American clinician with caution, mistrust, or even hostility (Everett, Proctor, & Cartmell, 1983).

Furthermore, the US government provides a large portion of the mental health services to Native Americans, and as a result, attitudes toward mental health care is heavily influenced by current governmental policies (Everett et al., 1983), which can also vary depending on resources and funding. There is often miscommunication regarding governmental policies on service deliveries and the mental health care professional providing the services, as well as policies in place that do not always guarantee or make clear what services are being provided. This confusion and inconsistency further perpetuates mistrust as well as frustration among Native American individuals who are seeking treatment (Everett et al., 1983).

Stigma and Shame

The stigma attached to having a mental illness is often a large deterrent against seeking services in Native Americans. Thompson and colleagues (1993) found that the degree of stigma associated with mental illness is negatively correlated with separation from traditional belief systems within the individual and family members. Furthermore, stigma is also related to the assimilation process that places Native Americans into the Westernized health care system. Specifically, the greater assimilation into Westernized culture, the more likely the individual will accept the Westernized diagnosis and treatment process (Hooper, 1991; Kleinman, 1996). This issue is complicated by the fact that Native American tribes are highly diverse and thus different tribes may have varying levels of acculturation. For example, Thompson et al. (1993) found that some tribal groups attach very little stigma to mental illness because they do not make distinctions from physical illnesses. However, other tribal groups attach high levels of stigma to psychiatric disorders, but accept the Western diagnoses and treatments.

Barriers to Treatment

Western diagnostic categories may not fit neatly with the manifestation of mental health symptoms in these populations. Native American communities suffer from clear disparities for many DSM-based diagnostic categories, particularly those associated with substance use, trauma and violence, and externalizing behaviors in children and adolescents (Gone & Trimble, 2012). Given these findings, it is possible that the manifestation of OCRDs in these populations may not fit adequately into Western diagnostic constructs, delaying a proper diagnosis and/or treatment.

Adequate and accessible treatment is another barrier particularly among Native Americans, as mental health services in these populations depend largely on governmental, public agencies, and funding. The Indian Health Service provides health care services to
over half of Native Americans in this country, yet these services still remain inadequately funded and of poor quality, creating larger issues regarding adequate diagnosis and treatment among these populations (Gone & Trimble, 2012).

Furthermore, mental health disorders are heavily impacted by socioeconomic factors and quality of life factors across populations. Native Americans have higher overall mortality, less education, and lower incomes than almost any other demographic in the US (Ogunwole, 2006; US Census Bureau, 2007). Additionally, they have some of the highest rates of suicide in the US (DHHS, 2009), owing largely to higher rates of mental health disorders, including trauma and substance abuse, as well as their poor socioeconomic conditions. These comorbid issues can further compound difficulty with mental health disorder management and treatment success among those in these populations who suffer from OCRDs.

Help-seeking for OCRDs

When considering help-seeking behaviors in these populations, findings by Thompson et al. (1993) suggest that Native Americans may have a preference for spiritual practices over traditional Western practices. Recent statistics suggest that 34–49% of Native American individuals diagnosed with behavioral disorders have sought treatment from traditional healers instead of mental health clinicians, and 16–32% of individuals reported seeking guidance from traditional healers in addition to biomedical services (Beals et al., 2005; Walls, Johnson, Whitbek, & Hoyt, 2006). Given the importance of traditional healers in Native American cultural practices, Gone (2010) suggests that the integration of traditional healing practices may improve therapeutic outcomes, as opposed to ignoring a client’s cultural values.

Native Americans also have attitudes toward mental illness and health care providers that can shape how they approach treatment. For example, many Native Americans believe disease is a consequence of supernatural phenomenon and that the respective healer is endowed with a supernatural power and thus will know exactly how to treat the problem (Jilek-Aall, 1976; President’s Commission on Mental Health, 1978). As a result, the Native American individual puts full responsibility in the provider to heal them and maintain a relatively passive role in the treatment process, which is contrary to typical CBT treatments for OCRDs.

Cultural Adaptations to Treatment of OCRDs

In Native American populations, having an understanding of the unique cultural approaches toward illness is critical to not only treatment adherence, but effective rapport-building as well. In Native American culture, the mind, body, and spirit are inexorably linked, and an illness that affects one part affects all the other parts (Mehl-Madrona, 1997). As a result, some Westernized approaches to diagnosis and treatment may not only be limiting, but not culturally appropriate in terms of the client’s belief system. Clinicians should be educated in the traditional healing practices within this culture and adapt diagnostic and treatment approaches to fit a model that is more holistic and reflective of the client’s cultural values.

Also, considering the important of family and community in Native American populations, integrating the family into the healing process should be encouraged.
In addition, clinicians should be aware of the vast diversity within the Native Americans, where different tribes have evolved with different customs, spiritual practices, and family values (Everett et al., 1983). The clinician should also consider differences in values, tribal identification, and level of acculturation when determining appropriate treatments (Rose & Gray, 2012).

Cultural Considerations in Arab Americans

Attitudes about Mental Health

There are 1.5 million people (0.5% of the population) with Arab ancestry living in the United States today (Asi & Beaulieu, 2013). While Arab Americans are an extremely heterogeneous group, many have negative attitudes toward mental illness (Abudabbeh, 1996). Arab Americans may hide a family member’s mental illness, only presenting to treatment when the illness has become severe. Additionally, Arab Americans may be more likely to view mental illness through a medical model, thus seeking first and foremost pharmacotherapy (Sayed, 2003). They may also attribute mental illness to evil spirits, head injuries, or a traumatic event (Lipson & Meleis, 1983).

However, attitudes may differ between Arab Americans based on their country of origin. For example, Lebanese culture is more accepting of psychological problems than other countries, while Arabs from Yemen support concealing problems (Nassar-McMillan & Hakim-Larson, 2003).

Arab Americans may be resistant to engaging in treatment for emotional concerns due to skepticism toward authority figures and mental health services in general (Abudabbeh, 1996). One study found that even Arab American clinic/hospital patients who significantly needed psychological services were resistant to mental healthcare referrals (Lipson, Reizian, & Meleis, 1987). One explanation for this resistance may be that seeking aid for personal or family problems from a mental health professional can be seen as a threat to the honor and loyalty of the family (Abudabbeh & Nydell, 1993).

Stigma and Shame

Arab Americans are a group that is largely misunderstood and much maligned in the media, often stereotyped as terrorists or fanatical Islamists. Thus, many Arabs have experienced discrimination, stereotyping, and other acts of racism (Moradi & Hasan, 2004), which can lead to difficulty in developing a positive ethnic identity (Jackson, 1997; Suleiman, 1988), and can negatively impact the therapist’s view of their Arab American clients, reducing the quality of treatment (Erickson & Al-Timimi, 2001). Many Arab Americans may feel embarrassed about their ancestors and homeland due to these stereotypes (Suleiman, 1988). These feelings of discrimination and embarrassment are likely responsible for studies finding that Arab Americans report increased scores on anxiety and depression measures, and have higher rates of posttraumatic stress disorder (Rippy & Newman, 2006).

There is a notable lack of research on the shame and stigma associated with mental illness in Arab American populations. One problem that may be contributing to this
is that individuals from the Middle East are typically categorized as non-Hispanic White. Therefore, it is not possible to know if their results are different from other non-Hispanic White participants if they were not studied separately (Abdullah & Brown, 2011).

The few studies that have been conducted reveal there is a cultural social stigma associated with mental health issues. Aloud and Rathur (2009) found that Arab Americans displayed less favorable attitudes toward the utilization of mental health services, and that use of services is associated with feelings of shame. Mental illness is perceived as a sign of weakness (Amer & Hovey, 2012), thus there is a fear of being labeled “crazy” (Gorkin, Masalha, & Yatziv, 1985). Soheilian and Inman (2009) found that in Arab American college students, more self-stigma (negative beliefs about the self-based on stereotypes) was related to increasingly negative attitudes toward counseling. One study even found that Arab women who had been victims of domestic abuse reported shame and embarrassment due to seeking mental health services outside the family (Abu-Ras, 2003).

**Barriers to Treatment**

Arab Americans may also be reluctant to engage in treatment due to fears about discrimination and racism from treatment providers. These fears are not unfounded, as one study found that health care workers held significantly negative attitudes about their Arab American patients (Lipson et al., 1987).

Another barrier that may be present between Arab Americans and mental health professionals is a difference in language and expression. Arab Americans may avoid expressing their true feelings, and may lean into the cultural pressure of expressing that which is easily acceptable for others (Dwairy & Van Sickle, 1996). Additionally, Arab Americans may be less inclined to engage in self-exploration, as this is not something that is emphasized in their culture, making it difficult to do so once in treatment (Dwairy & Van Sickle, 1996). Finally, there may be language barriers, as there are not an abundance of Arabic-speaking mental health professionals readily available, and with so many dialects in the Arabic language, it may be difficult to communicate, even amongst Arabs (Nassar-McMillan & Hakim-Larson, 2003).

Many Arab Americans may avoid Western mental health services because of a lack of exposure to such services, and a lack of knowledge about mental health in general (Aloud & Rathur, 2009; Erickson & Al-Timimi, 2001). Most individuals seek help from a family member during difficult times (Abudabbeh, 1996). If they do decide to begin treatment, Arab Americans may have misconceptions about how treatment works, with many believing that their mental health professional is an “expert” who will give them specific advice and directions for their problems (Gorkin et al., 1985). This may be due to the way they have received guidance from elders in the past, who are willing to provide detailed advice, or a respect for authority (Abudabbeh, 1996).

Additionally, the symptoms of Arab Americans are often misdiagnosed, as emotional distress is often manifested through physical complaints, such as body aches or gastrointestinal problems (Gorkin et al., 1985; Racy, 1980). Thus, a thorough assessment is essential.
Help-seeking for OCRDs

In times of difficulty, Arab Americans are more likely to turn to sources other than mental health professionals for help. Because of the strong emphasis on family in Arab culture, individuals often seek assistance from an older, same-sex family member (Abudabbeh, 1996; Jackson, 1997). Additionally, Arab individuals may engage in prayer to seek guidance during difficult times (Al-Krenawi, Graham, Dean, & Eltaiba, 2004). Arab Americans who are Shiite Muslims may have an even higher tendency to seek consult from a religious leader (Nassar-McMillan & Hakim-Larson, 2003). Illustrating the preference toward seeking help from familiar sources, a study by Aloud and Rathur (2009) found that Arab Americans were most likely to seek help from a family doctor, followed by a family member. They were more likely to look to a religious healer than to seek help from a mental health professional.

Cultural Adaptations to Treatment of OCRDs

Due to these differences in cultural values and in help-seeking behaviors, treatments may need to be augmented to be culturally sensitive for Arab Americans. Arab Americans rely heavily on their families during times of distress, so it may be more likely that family members are included in the therapeutic process (Nassar-McMillan & Hakim-Larson, 2003). Arab Americans may view their psychological difficulties in the context of their effect on the family, and forging an identity that is separate may not be something that is valued in treatment (Erickson & Al-Timimi, 2001). Therefore, a clinician may have to frame treatment as beneficial to the family, not just to the individual. Additionally, because of the emphasis on familial support, it may be particularly important to assess for family accommodations and their impact in an Arab American clients with OCRDs.

In assessing for OCRDs, it may also be important to keep in mind the repetitive behaviors involved in Islamic traditions and rituals. A series of case studies reported that Arab American individuals with OCD may become troubled by abnormal sensations related to prayer (Abouhendy & Jawad, 2013). Prior to prayer, the body must be systematically cleaned (Mahgoub & Abdel-Hafeiz, 1991), and bodily actions (such as passing urine) may invalidate the cleansing process (Abouhendy & Jawad, 2013). Individuals may become obsessed with their purity, and cleanse themselves repeatedly if they fear that their cleansing has become invalidated. Because of the importance of cleanliness and purity, it is important to differentiate rituals that are performed in the context of Islam versus those that are performed excessively. In terms of OCD-specific symptomology, it is common for cleanliness concerns to be mixed with religious concerns.

Because of the role that religion plays in the lives of many Arab Americans, it may be helpful to elicit the support of a religious figure (Nassar-McMillan & Hakim-Larson, 2003). This may be a benefit in treatment, as religious values have been associated with life satisfaction in Arab Americans (Faragallah, Schumm, & Webb, 1997). Mental health professionals can work collaboratively with the client, and, if appropriate, the religious leader, in order to incorporate religion into the treatment plan.

Another key factor is level of acculturation and immigrant status. Attempting to become acculturated is a source of stress that may vary for first-generation Arab Americans, depending on the reasons for emigration, their ability to visit their home
country, and their language abilities (Erickson & Al-Timimi, 2001). Many refugees from Arab countries have experienced trauma related to war, and this trauma should not be disregarded in treatment (Nassar-McMillan & Hakim-Larson, 2003). There has been scant research concerning stigma, help-seeking behaviors, barriers to treatment and cultural adaptations for OCRDs (esp., BDD, TTM, excoriation disorder, and hoarding disorder) in Arab Americans. Although these factors may be similar across mental disorders within this population, considerable research is needed to draw viable conclusions specific to OCRDs.

Conclusion

Some research has been conducted to better understand ethnic minority challenges in obtaining mental health care. However, little is known about OCRD-specific mental health attitudes among minority groups. Low income, language barriers, and access to providers appear to be major problems, but more research is needed to understand barriers to OCRD treatment faced by ethnoracial minorities. Additionally, minorities in the US tend to be wary of traditional Western mental health care, due in part to cultural mistrust, concerns about discrimination, and concerns that their groups’ culture and values will not be appreciated.

Thus, treating ethnoracial minorities may involve more challenges and require a special sensitivity. It is important for clinicians to take time to learn about the culture and values of their minority clients. Ignoring cultural values or differences using a colorblind ideology may cause minority clients to be more reluctant to disclose to a clinician (Constantine, Redington, & Graham, 2009; Terwilliger et al., 2013). Therapists should also remember that that ethnic and racial minorities are not a single homogeneous group, therefore generalizing culturally relevant principles may not encompass the value systems of all minorities. Making treatment a more collaborative process with minority clients may significantly improve therapeutic outcomes by giving the client more control over their recovery and establish more trust between the therapist and client.

Treatment for OCRDs in ethnoracial minorities involves a considerable amount of patience, rapport building, assessment, acknowledgment of cultural values, and psychoeducation. Not all traditional Western psychotherapies foster these ideologies, so it is essential for clinicians to be sensitive to a minority client’s value system and potential negative attitudes toward experiencing a mental illness and mental healthcare overall. Furthermore, the incorporation of culturally salient treatment practices may significantly improve therapeutic outcomes within suffers from these groups.

References


