OCD IN ETHNORACIAL MINORITIES
SYMPTOMS, BARRIERS TO CARE, AND CULTURAL CONSIDERATIONS FOR TREATMENT

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Obsessive-compulsive disorder (OCD) is a multifaceted and functionally disabling condition involving distressing obsessions and repetitive compulsions. The National Comorbidity Survey Replication found a 1.3% one-year prevalence rate and 2.7% lifetime morbidity risk for OCD in the United States (US) population (Kessler et al., 20012; Ruscio et al., 2010).

Although OCD rates are generally invariant cross-culturally (Himle et al., 2008; Karno et al., 1988; Ruscio et al., 2010; Williams & Steever, 2015; Zhang et al., 1998), there remains a paucity of knowledge about the disorder in ethnoracial minority groups (Williams, Powers, et al., 2010). This could be due to underrepresentation of minorities in OCD treatment centers, a major source of symptom data for OCD research (Fernandez de la Cruz et al., 2015; Snowden et al., 1990; Williams, Sawyer, et al., 2015). Poor minority participation also suggests stigmatic cultural attitudes toward mental illness and related services, among other barriers to treatment.

This chapter reviews symptom presentation, barriers to treatment, and possible cultural considerations for treatment of OCD in three ethnoracial groups in the United States (African Americans, Latino/Hispanic Americans, and Asian Americans). It is important to note that the information provided here might not generalize to other minority or cultural groups either in the United States or other countries.

SYMPTOM PRESENTATION

AFRICAN AMERICANS

Although approximately 42 million (14.0%) of the US population identify as African American wholly or in part (U.S. Census Bureau, 2010), research on OCD in African Americans has been scarce, until recently (Williams, Powers, et al., 2010). The National Survey of American Life (NSAL) examined mental disorders in African Americans, Blacks of Caribbean descent, and non-Hispanic Whites (Heeringa et al., 2004). Results indicated that 1.6% of African Americans and Blacks of Caribbean descent had OCD, in the range of what has been reported in other groups, and compared with non-Hispanic Whites, they had high psychiatric comorbidity (i.e., rates of 93.2% and 95.6%, respectively, for at least one other lifetime psychiatric disorder), as is the norm for OCD (Himle et al., 2008; Williams, Elstein, et al., 2012).

Williams, Proetto, et al. (2012) subsequently identified six symptom dimensions in African Americans with OCD: contamination/washing, hoarding, sexual thoughts/reassurance seeking, aggression/mental compulsions, symmetry/perfectionism, and doubt/checking. Although these factors were qualitatively comparable to mostly White samples, important differences were found. African Americans reported dramatically increased contamination-related symptoms compared with European Americans (Williams, Elstein, et al., 2012) and were twice as likely to report animal concerns, findings consistent with data from nonclinical samples (Wheaton et al., 2013; Williams, Abramowitz, et al., 2012; Williams & Turkheimer, 2007). These symptoms may be conceptualized as maladaptive counteractions of negative cultural stereotypes and historical events perpetrated against African Americans. For example, African Americans have suffered experiences of segregation (e.g., European Americans fearing close contact with "dirty" people of color; Devine, 1989) and animal attacks (e.g., dogs being used to hunt for slaves or attack civil rights protestors; Williams, Elstein, et al., 2012). Additionally, there was
a significant correlation between lower socioeconomic status (SES) and greater contamination concerns in African Americans, which might be explained by a greater exposure to contaminants in low income communities (e.g., lead paint, pollution, etc.; Williams, Elstein, et al., 2012; Williams & Tushkhelme, 2007).

Other concerns such as sexual or aggressive obsessions may not be readily disclosed by African Americans for fear of confirming stereotypes about being violent or sexually deviant. Furthermore, African Americans may be reluctant to endorse negative religious obsessions, given the importance of religious faith within this community (Alvarez et al., 2008).

In a Costa Rican study, participants reported lower symptom severity (i.e., distress and functional interference) among Indian American participants were marginally higher than for the non-Asian American participants.

Jaisoorya et al. (Jaisoorya et al., 2009) observed the most common obsessions to be contamination (40.8%), symmetry or exactness (42.2%) followed by aggression (36.0%). The most common compulsions were checking, washing, and repeating rituals. A culture-bound disorder that is seen particularly in Japan is Tainjin Kyohusho, an interpersonal fear disorder, of which there are several variants, including the obsessive fear of offending others due to a physical defect or offensive facial expression (Vriends et al., 2013). Liu et al. (2008) noted that some symptom dimensions in Latino/Hispanic American populations are sparse. Available evidence seems to indicate a focus on contamination concerns, unless salient culturally relevant concerns apply. For example, Williams et al. (2005) found elevated contamination concerns in a nonclinical Latino/Hispanic American sample. Similarly, Nicolini et al. (1997) observed in a Mexican sample that the most common obsessions were contamination related (58.0%), followed by sexual (31.0%) and aggressive obsessions (13.0%). Interestingly, a study in Rio de Janeiro analyzed the content of reported obsessions, with the most common theme centering on aggression (Fontenelle et al., 2004), discrepant from conventionally contamination-focused symptom manifestation in several other cultures (Masanaga et al., 2008). A plausible culture-specific explanation for this emphasis on harm avoidance were the escalating mortality and morbidity rates resulting from violent causes in that urban city; a similar emphasis might thus be expected within crime-ridden American inner cities. More research on the latter is required.

LATINO / HISPANIC AMERICANS

In the United States, about 50.5 million (16.0%) are of Latino or Hispanic origin (U.S. Census Bureau, 2011). OCD in Latino/Hispanic American populations is understudied. In the only case report published, “Paul,” a 40-year-old Cuban American, experienced intrusive thoughts about committing suicide and how such an event would impact his family (Wetterneck et al., 2015). Concerns about the possible consequences of such symptoms on the family are consistent with the Hispanic cultural emphasis on family ties. His symptoms eventually subsided with cognitive-behavioral therapy despite impeding cultural barriers.

Research that addresses OCD in Latin American populations provides insights that may be applicable to the American Latin/o Hispanic population. Comparisons of OCD prevalence between Latino and European American populations in the United States are inconsistent across studies (Karno et al., 1989; Weissman et al., 1994), whereas methodologically different studies in Latin America note a lifetime prevalence rate of 1.4% in Mexico City, 1.2% in Chile, and 3.2% in Puerto Rico (Canino et al., 1987; Caraveo-Anduaga et al., 2004; Vicente et al., 2006).

In a Costa Rican study, participants reported lower OCD symptom severity (e.g., less perceived distress, lower functional impairment), compared with their US counterparts (Chavira et al., 2008). Given that the Costa Rican participants were primarily based in an agrarian society, they might have fewer psychosocial stressors and greater room for symptom accommodation (e.g., greater ease of access in Costa Rica that facilitates not driving to avoid harming others).

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ASIAN AMERICANS

In the United States, 17.3 million people (5.6%) identify as Asian, within heterogeneous subgroups (U.S. Census Bureau, 2012). There is a paucity of research on OCD in Asian Americans. Wheaton et al. (2013) reported that an Asian American college sample endorsed more concerns about contamination and obsessive beliefs than European Americans. Holt et al. (2003) described the case of an Asian American woman with comorbid OCD and BDD, whose mental health issues were intertwined with her difficulties in acculturating and concerns that she did not conform to American standards of beauty. More insights into OCD in Asian Americans can be gleaned from research on their East, South, and Southeast Asian counterparts.

Li et al. (2009) found that the most commonly reported symptoms in patients in mainland China were obsessions about symmetry (67.6%), contamination (43.2%), and then aggression (31.7%). The cultural emphasis on harmony stemming from Confucian precepts might be linked to fewer reports of obsessions about aggression, but greater concerns about symmetry. In a Japanese sample, Matsunaga et al. (2008) observed the most common obsessions to be about contamination (40.8%), symmetry or exactness (42.2%) followed by aggression (36.0%). The most common compulsions were checking, washing, and repeating rituals. A culture-bound disorder that is seen particularly in Japan is Tainjin Kyohusho, an interpersonal fear disorder, of which there are several variants, including the obsessive fear of offending others due to a physical defect or offensive facial expression (Vriends et al., 2013). Liu et al. (2008) noted that some symptom dimensions in Latino/Hispanic American populations are sparse. Available evidence seems to indicate a focus on contamination concerns, unless salient culturally relevant concerns apply. For example, Williams et al. (2005) found elevated contamination concerns in a nonclinical Latino/Hispanic American sample. Similarly, Nicolini et al. (1997) observed in a Mexican sample that the most common obsessions were contamination related (58.0%), followed by sexual (31.0%) and aggressive obsessions (13.0%). Interestingly, a study in Rio de Janeiro analyzed the content of reported obsessions, with the most common theme centering on aggression (Fontenelle et al., 2004), discrepant from conventionally contamination-focused symptom manifestation in several other cultures (Masanaga et al., 2008). A plausible culture-specific explanation for this emphasis on harm avoidance were the escalating mortality and morbidity rates resulting from violent causes in that urban city; a similar emphasis might thus be expected within crime-ridden American inner cities. More research on the latter is required.

In the comparatively rural Indonesian province of Bali, Bloch et al. (2001) noted that Indian participants differed from White and non-White samples in that urban city; a similar emphasis might thus be expected within crime-ridden American inner cities. More research on the latter is required.

Jainardhan Reddy et al. (Jainardhan Reddy et al., 2005) noted that the lifetime prevalence rate of OCD in India is relatively low at 0.6%, and that typical obsessions tend to focus on contamination, aggression, symmetry, sexual and religious themes, and pathological doubt (Girishchandra et al., 2003). Bloch et al. (2003) reported that Indian participants differed from White and non-White samples in that the typical five-factor model of symptoms needed to be modified for Indians to include the need for tactile contact, possibly linked to cultural traditions involving touching (e.g., touching the feet of elders as a sign of respect). Additionally, Washington et al. (2008) examined two measures of OC symptoms in a large nonclinical college sample of European American, African American, Latino/Hispanic American, Southeast Asian American, and Indian American students, and found that Indian Americans had higher symptom frequency endorsement than did other non-Asian American participants, and that the association between symptom frequency and diagnostic severity (i.e., distress and functional interference) among Indian American participants were marginally higher than those for the non-Asian American participants.

Jaisoorya et al. (Jaisoorya et al., 2009) subsequently found that Indian males with OCD tended to report sexual and symmetry obsessions coupled with checking and repeating compulsions, whereas concerns about dirt and contamination symptoms were reported more often by Indian females (Labad et al., 2008). Cherian et al. (2013) had similar findings: Indian men reported greater frequencies of sexual and religious obsessions, pathological doubt, and checking and repeating compulsions, whereas Indian women were more likely to suffer from fear of contamination. The consistent emphasis on contamination concerns in Indian females could plausibly be due to their greater exposure to unclean conditions, in turn explained by Indian females being socialized to do a greater share of domestic work.

OCD research within the cosmopolitan, multilingual Southeast Asian nation of Singapore might be somewhat connected to the manifestation of the disorder in Asian Americans. Subramaniam and colleagues (2012, 2013) examined a large sample of Chinese, Malay, and Indian Singaporeans. The lifetime prevalence rate of OCD was 3.0%, OCD was most common between the ages of 35 to 49, and no ethnic differences were associated with OCD. Psychiatric and medico-comorbidity was common, and those in treatment took an average of 9 years from onset to seek help. Women with OCD reported more cognitive and social disability than their male counterparts, indicating the need for mental healthcare providers to provide culturally attuned assistance (e.g., evening and weekend clinic hours, and a stronger focus on improving cognitive and social functioning).

In the comparatively rural Indonesian province of Bali, Lembis (2003) noted that the most reported obsession among OCD patients was the need to know the identities of passers-by. Obsessions about magic, witchcraft, and spirits were also reported, which are religious themes salient within Balinese Hindu culture. Culture can color perceptions of symptoms, as demonstrated by Washington and colleagues (2008). In that study, Southeast Asian students in an American college more frequently endorsed OC symptoms than did participants of other ethnic minorities, although this did not mean increased diagnostic severity in terms of distress and functional interference, suggesting that these OC behaviors might not be viewed as pathological, but are probably more reflective of cultural characteristics, traditions, and/or beliefs.
On a related note, African Americans’ underutilization of mental healthcare services may stem partly from their belief that such services are designed generally for non-Hispanic Whites (Alvarez et al., 2008). African Americans may view the prototypical psychologist as an older White male who does not understand the economic difficulties (Thompson et al., 2004). Preferences for an ethnically matched clinician (Malat et al., 2010) are typically not met, as African Americans make up only about 5% of psychologists (U.S. Bureau of Labor Statistics, 2012). Therefore, African Americans may view mental health settings negatively and have a hard time trusting their therapists, which may interfere with positive therapeutic outcomes in this population in ways that non-Hispanic Whites may not experience (Sue et al., 1991). For example, Williams et al. (1998) noted that a fear of being labeled insane, among other issues like excessive shame and a sense of uniqueness, complicated exposure and response prevention (ERP) treatments of two African-American women with OCD. This may explain why African Americans may be less likely to experience symptom reduction with empirically supported interventions (Pole et al., 2008). Healthcare professionals may also perpetuate lower satisfaction during treatment and higher dropout rates by failing to consider cultural mistrust of mental health professionals may make it difficult to consider treatment for mental illness. Masuda et al. (2012) found that recent African American undergraduates perceived mental illness negatively as an integral part of how they viewed mental health overall, and also endorsed the self-concealment of personal information, potentially contributing to poor help-seeking attitudes. Pathological stereotyping of African Americans, including notions such as that they are lazy, poor, unintelligent, criminal, and sexually predatory/deviant (Williams, Gooden, et al., 2012), contributes to a sense of stigma and shame, perpetuates the idea that such persons do not have desirable characteristics, and provides justification for unfair treatment by others. Indeed, Williams, Domanico, et al. (2012) found that compared with their White counterparts, a greater percentage of African Americans endorsed significant clinician-related concerns related to unfair treatment due to race or ethnicity, were uncomfortable discussing their problems with a professional, and reported a fear of being misunderstood (Ayalon et al., 2007; Williams, Gooden, et al., 2012). African Americans have been reported to exhibit discomfort and anxiety in the presence of an evaluator of any race, even another African American (Williams, Chasson, et al., 2015). Misdiagnosis may also be a significant barrier to treatment, as African Americans may have non-normative OCD symptom presentation, compared with non-Hispanic Whites. Perhaps due to therapists’ acceptance of pathological stereotypes, African Americans tend to be overdiagnosed with psychiatric disorders for symptoms of OCD, compared with non-Hispanic Whites (Ninan et al., 1993), and are more likely to be hospitalized for presumed psycho­sis, even after controlling for severity of illness and SES (Snowden et al., 2009; Whaley et al., 2009).

Additional concerns endorsed by African Americans include financial burden and access to treatment (Williams, Domanico, et al., 2012). Specifically, the most affected individuals were those with incomes low enough to not have access to private insurance, and too high to qualify for public services.

Similar to African Americans, Latino/Hispanic Americans tend to perceive mental illness negatively due to cultural norms. For example, Nadeem et al. (2007) found that immigrant Latina and African American women were significantly more concerned about the negative stigma attached to mental health than, compared with US-born non-Hispanic Whites. In Nicoliti et al.’s (1997) study of OCD in Mexican, only 37% of the sample were male, possibly due to the cultural tendency for Mexican men to deny suffering from mental illness. This sex discrepancy might stem from the attitudes of machismo and caballosismo. Machismo can be defined as hypermasculinity, aggression, and other predominantly negative male behaviors, whereas caballosismo embodies positive male images of the nurturing provider who respects others, defends those that are weak, and lives a chivalrous ethical code (Arciniega et al., 2008). These cultural values might unfortunately discourage Latino/Hispanic men from seeking treatment from mental illness, and reduce treatment-seeking behaviors or make treatment extremely difficult (Saez et al., 2009).

Seeking assistance from non-mental healthcare avenues may typify help-seeking behavior in African Americans with OCD. Data from the NSAL (African Americans, n = 3,570) indicate that African Americans with OCD employ general medical professionals as the most common option for their OCD-related concerns (Himle et al., 1988). Friedman et al. (1993) investigated help-seeking behaviors of African Americans in a dermatology clinic, and found that 15% of patients suffered from undiagnosed OCD, suggesting that members of this community may seek medical help before mental health treatment. Findings by Alvarez et al. (2008) illustrate that African Americans may view church as a highly acceptable support system outside of their 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. Furthermore, Himle et al. (2012) examined religion in African Americans with OCD and found religious coping to be positively associated with OCD symptom severity, suggesting that African Americans with OCD mobilize religious resources to cope with their worsening symptoms.
ASIAN AMERICANS

Despite the heterogeneity of Asian American subgroups, many researchers have studied the mental health care and treatment-seeking attitudes of these populations together because of similar cultural views in comparison to their Western counterparts (Abe-Kim et al., 2007; Kim et al., 2009).

Although previous work has suggested that Asian Americans endorse negative attitudes toward mental illness, many studies have employed self-report measures that can elicit negative reactions as a result of pressure to disclose (Garewski et al., 2004). To circumvent this issue, Cheon and Chiao (2012) investigated implicit and explicit attitudes in Asian Americans and non-Hispanic Whites, and found that Asian American subjects nevertheless endorsed more negative implicit attitudes toward mental illness. Furthermore, Asian Americans explicitly wanted a greater social distance from people with mental illness compared with non-Hispanic Whites, providing further evidence that Asian American populations may not view mental illness favorably. Additionally, the Asian Americans preferred to disclose somatic rather than psychological symptoms, as the disclosure of emotional impairment or stress can be seen as personal weakness or dishonoring the family/community, contributing to feelings of isolation, guilt, and shame, and making it more difficult to seek or adhere to treatment (Chu et al., 2011; Gilbert et al., 2004; Leong et al., 2011).

Positive stereotypes about Asian Americans may ironi-
cally be a source of distress and difficulty. Son and Shelton (2011) found that when Asian American college students expected European American students to stereotype them as intelligent and academically successful, they felt more anxious and experienced internal pressure to change to fit in. Positive stereotypes might also be linked to Asian Americans endorsing lower rates of psychopathology and being less likely to seek professional services for mental illness (Leong et al., 2011). In terms of negative stereotypes and discrimination, Park et al. (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 challenging in the midst of displays of antisocial behavior.

An additional barrier to mental health treatment for Asian Americans stems from their tendency to use informal sources of support, turning to family and friends, or trying to work problems out on their own until the issue becomes unmanageable (Durvasula et al., 1996; Kearney et al., 2005; Nariyko et al., 1992; Zhang et al., 1998). Asian American culture generally values self-control and intellectualization over emotional expression, resulting in a tendency to internalize mental distress and tolerate suffering as opposed to engaging in emotional self-disclosure (Mysorekar, 2007; Rantscherry-Müller, 1993). The additional tendency of Asian Americans to somatize psychological issues (Leong et al., 2011; Ramakrishna et al., 1992) could mean that they may seek help from general physicians more often than mental health professionals. Therefore, Asian American individuals run the risk of receiving superficially suitable but ineffective healthcare services for their symptoms.

Religious belief in Buddhism, Confucianism, and Hinduism in the Asian American community influence perceptions of the source of mental illness. For example, bad karma is more often cited as a reason for illness by Indian Americans, reflective of the Hindu belief that current illnesses are the outcome of one’s past wrongdoings (Chandiramani et al., 2003). Hindu devotees may thus see mental illness as a deserved punishment, and not actively seek help. In contrast to the Western biomedical model, Asian Americans more often believe in the integration of spirit, body, and mind when addressing mental illness, and may also be more likely to seek religious remedies, spiritual healing, or mind-body treatments like Ayurvedic or Chinese medicine, instead of established Western mental health treatments (Chakraborty et al., 2013; Chu et al., 2011; Durvasula et al., 1994; Grover et al., 2014).

Asian Americans with OCD may present with symp-
toms, attitudes, and beliefs similar to those of White Americans, and are likely to conceal OCD symptoms and avoid seeking treatment due to the risk of misdiagnosis within this population. System-
related issues and socioeconomic difficulties within the Asian American community act as additional barriers to treatment. For example, low insurance coverage and pov-
ercy among Southeast Asian Americans might be linked to their poorer psychological functioning, relative to other Asian American subgroups (Reeves et al., 2004). There are also issues with availability of culturally and linguisti-
cally appropriate services for Asian Americans (Chandras, 1997). These individuals may be unfamiliar with counseling and psychotherapy as treatment options. Additionally, con-
ceptualizing that their cultural values may not be present in mental health treatment may deter treatment seeking and hinder the therapeutic process.

CULTURAL CONSIDERATIONS FOR TREATMENT

AFRICAN AMERICANS

Research on specific treatment issues in African Americans with OCD has been sparse, but available evidence indicates that because of stigmatic attitudes, African Americans are likely to conceal OCD symptoms from clinicians (Friedman et al., 2003). The likelihood of dis-
closing such symptoms increases, however, once a
therapeutic alliance is formed, suggesting the importance of good rapport in treating African Americans with OCD (Hatch et al., 1996). Clinicians should also take more time to diagnose African American clients who report other anxiety symptoms, as OCD may also be present. The negative stigma surrounding mental illness within the African American community makes open discussion of emo-
tional problems difficult and can cause OC behaviors to be tolerated rather than be viewed as problematic. 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 their OCD, normalize the disorder, and reduce stigma surrounding mental illness overall. Being transparent about what an OCD diagnosis means for a client, as well as what treatment entails, will break down some barriers that have historically dispropor-
tionately impacted this population, and make it easier for clinicians to establish strong rapport (Mausa et al., 2012; Williams et al., 2013).

As African Americans with OCD are more likely to endorse prayer as being important during times of stress, and are more likely to function within an extended fam-
ily structure, integrating concepts from these domains into psychotherapy may be useful (Himle et al., 2012; Ruggle, 1994). Specifically, an Afrocentric approach to treatment can be adopted, in which faith, family support, resiliency, and optimism are highlighted (e.g., empha-
sizing members of an African American client’s support network who may be a good source of strengths and sup-
thority treatment, Baldwin et al., 1985; Jackson et al., 1992).

LATINO/HISPANIC AMERICANS

Hernandez et al. (Hernandez et al., 2005) found that Latino/Hispanic Americans with OCD tend to have prob-
lems with interpersonal functioning, which is an issue because the family tends to be a primary means of support for mental health concerns in this collectivistic culture (Gloria et al., 2000). Clinicians should therefore make an effort to integrate family into the treatment process via family consultation and family therapy sessions, in order to improve adherence and bolster the therapeutic alliance. The metanalysis by Thompson-Iolland et al. (2014) supports these suggestions, as family-inclusive treatment for OCD was largely effective in reducing symptom severity and fam-
ily accommodation. Additionally, given the strong focus on religion within this population, incorporating faith into empirically supported treatments may also be helpful for attaining positive therapeutic outcomes. Assessing religious beliefs prior to treatment adaptation is essential, however, as Latino/Hispanics differ in the personal significance of their religious beliefs.

Cross-cultural applications of evidence-based treat-
ments for OCD in Latino/Hispanics based on diagnos-
tic constructs developed for Westernized presentations of symptoms remain questionable. Clinician knowledge of socioeconomic, cultural, and linguistic barriers faced by Latino/Hispanic clients, and how they can influence OCD symptomology, is therefore vital for treatment suc-
cess (Wetterneck et al., 2012). For example, it may be help-
feful to educate clinicians on how to approach treatment for Latino/Hispanic men, in light of their machismo and callandarismo culture. It may be more useful to work with male clients to bolster rapport. Male clinicians could also educate male clients on the importance of addressing psychological concerns and the value of behaviors such as
CONCLUSIONS

OCD research in ethnic minority groups is sparse, leaving many gaps in our understanding of the disorder and its associated characteristics in various people groups. For example, no research on OCD in Native American patients could be located for inclusion in this review. Ongoing cross-cultural research in OCD can help us better understand how cultural beliefs can worsen, buffer against, or otherwise alter the symptom presentation and experience of OCD. This knowledge is then vital to the development of empirically supported treatments for individuals from ethnic minority backgrounds, as well as for determining the applicability of contemporary literature to diverse cultural groups.

In terms of practice, it is undesirable that cultural sensitivity is important in the diagnosis and treatment of OCD. Williams, Sawyer, et al. (2015) showed that minorities with OCD experienced significantly longer hospitalization than non-Hispanic White patients, even through mean symptom severity at admission and discharge did not differ between groups. This underscores the point that cultural differences at all phases of the therapeutic process are likely to figure heavily in addressing OCD in ethnic minority groups. Ethnic matching is an effective but rarely achieved solution (Ziguras et al., 2003). Therefore, training in cultural competency and sensitivity is especially important for all clinicians (Constantine et al., 2009; Tewilliger et al., 2013). Specifically, OCD treatment for ethnic minority involves considerable patience, intensive assessment, psychopharmacology, and rapport building, as well as unacknowledged understanding of cultural values. It is also essential for clinicians to be sensitive to a minority client’s potential negative attitudes toward the concept of mental illness and mental health services. Importantly, therapists should remember that ethnic minority are heterogenous, and culturally relevant principles may not generalize across the value systems of all minorities. Last, engaging in collaborative therapy with minority clients may significantly improve therapeutic outcomes by building greater trust between the therapist and client, as well as giving clients more control over their recovery.

REFERENCES


significant portion of adults with OCD report that their symptoms began while they were in middle school or high school, and sometimes even in grade school. Often these same adults report that they were not properly diagnosed for years, delaying the introduction of appropriate treatment.

Although statistical reports vary somewhat, it is generally accepted that 1 in 200 children and adolescents have OCD (see chapters 3, 4). This means that nearly all schools have at least a few children with OCD in their student body at any given time, and larger schools and college campuses may have dozens, even scores of students. Therefore, knowingly or not, over the course of their careers, nearly all school personnel will come into contact with at least one student, and probably many more than that, who is struggling with OCD. From the time a child enters full time pre-school or kindergarten, and through high school years and beyond, school personnel as a whole spend more time with students on any given school day than do their parents or friends.

This means that school personnel are in a unique position to provide early identification of OCD in children and adolescents, and can serve to reverse the delay of a correct diagnosis that so many adults with OCD have complained about from their own histories. The difficulty is that school personnel don’t always know what to look for. Once OCD is identified, school personnel can provide direction to appropriate treatment, thus reversing the delay in students getting the right help; but here, too, even guidance counselors don’t often know what the best treatment is or where it can be found. Finally, school personnel, in tandem with mental health professionals, can even play an important role in the treatment process by altering how they respond to the student with OCD; but at present most are unaware of how they might fit in to such a treatment process.

If one of the main goals for those involved in OCD treatment, research, and advocacy is education leading to earlier detection and quicker access to appropriate treatment, then addressing this gap in knowledge by school personnel should be an imperative.

This chapter looks at how OCD is typically manifested in the school environment. It examines how a treatment protocol would be developed to reverse and minimize the effects of the disorder on school-related functioning. Finally, it examines how school personnel, together with mental health professionals and parents, can become active participants in OCD therapy.

OCD IN THE SCHOOL SETTING

The manifestation of OCD in the educational setting varies widely. Perhaps the most influential variable affecting symptom presentation of OCD in the school setting is the type of OCD experienced by the student. The “flavors,” or “dimensions” of OCD subtypes that are present (see chapter 8) will dictate the particulars of the obsessions and the resulting compulsions. This separation of OCD into different subtypes can get complicated, because very often they overlap with one another, and a single compulsive behavior may be executed as a result of several different OCD subtypes simultaneously exerting influence over the student. Examining these subtypes individually, though, is a good exercise in exploring how they may manifest as in-school behaviors that could be identified by school personnel.

“Washing/cleaning OCD,” typically one of the more common incarnations of the disorder, usually has fear of contamination at the core of the obsessional content. Compulsions may be evidenced by dry, cracked, red, and even bleeding hands, or the wearing of gloves. Students