Validation of the Yale-Brown Obsessive-Compulsive Severity Scale in African Americans with obsessive-compulsive disorder

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A B S T R A C T
The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is widely used in the assessment of obsessive-compulsive disorder (OCD), but the psychometric properties of the instrument have not been examined in African Americans with OCD. Therefore, the purpose of this study is to explore the properties of the Y-BOCS severity scale in this population. Participants were 75 African American adults with a lifetime diagnosis of OCD. They completed the Y-BOCS, the Beck Anxiety Inventory (BAI), the Beck Depression Inventory-II (BDI-II), and the Multigroup Ethnic Identity Measure (MEIM). Evaluators rated OCD severity using the Clinical Global Impression Scale (CGI) and their global assessment of functioning (GAF). The Y-BOCS was significantly correlated with both the CGI and GAF, indicating convergent validity. It also demonstrated good internal consistency (α = 0.83) and divergent validity when compared to the BAI and BDI-II. Confirmatory factor analyses tested five previously reported models and supported a three-factor solution, although no model exhibited excellent fit. An exploratory factor analysis was conducted, supporting a three-factor solution. A linear regression was conducted, predicting CGI from the three factors of the Y-BOCS and the MEIM, and the model was significant. The Y-BOCS appears to be a valid measure for African American populations.

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1. Introduction
1.1. Assessment of OCD in African Americans

Obsessive-compulsive disorder (OCD) is a highly disabling and distressing disorder, which has made it one of the leading causes of disability worldwide (Lopez and Murray, 1998). OCD is characterized by the experience of distressing obsessions (e.g., thoughts of contamination, symmetry, illness) and continuous compulsions (e.g., checking, hoarding, and ordering) as a way to avoid, assuage, or decrease the distress occasioned by the obsessions. OCD affects an estimated 1.6% of the American population, causing significant and pervasive impairment in multiple domains, including home life, work, and relationships (Himle et al., 2008; Ruscio et al., 2010). In fact, a few decades ago, OCD-related costs had already been estimated at over $8 billion dollars annually in the US (DuPont et al., 1995). Therefore, ongoing research to improve our understanding of the disorder is an important public health challenge.

There has been increasing interest in understanding OCD cross-culturally. The phenomenology of the disorder has been found to differ across ethnic and racial groups (Williams and Steever, in press). Examples of this include differences in the types of obsessions and compulsions reported by African Americans with an OCD diagnosis, such as increased contamination concerns, especially with respect to animals, and greater fears about being misunderstood by others (Williams et al., 2012b).

Although African Americans appear to experience OCD at equivalent rates as the general population (Zhang and Snowden, 1999; Himle et al., 2008; Ruscio et al., 2010), they are under-represented in OCD treatment clinics and research studies. For example, a survey of all North American OCD clinical trials from 1995–2008, found that among 2221 participants, only 1.3% were African American (Williams et al., 2010). For each of the 21 studies reviewed in that investigation, N for African Americans ranged from zero to a maximum of 5. It is suggested that this shortcoming is due, in part, to a failure to identify OCD due to its heterogeneous presentation, cultural differences in symptom expression, and inadequate recruitment techniques (Friedman et al., 2003; Williams et al., 2012b, 2012c; Williams and Steever, in press).

A related problem could be the use of clinical measures that are not valid for this population. Research has shown that many measures of OCD lack validity in non-clinical samples of African Americans with OCD.
conducted a study examining the psychometric properties of the Y-BOCS as having separate subscales representing obsessions and compulsions. No specific statistics were conducted for models using only African Americans in this study.

To date, no studies have explored the properties of the Y-BOCS severity scale in African Americans who have been diagnosed with OCD. Therefore, the purpose of this study is to examine the psychometric properties of the Y-BOCS severity scale in a well-characterized sample of African Americans diagnosed with the disorder. We hypothesize that the factor structure will match the findings from the non-clinical sample of African Americans described in Washington et al. (2008). Further, we will explore the validity of previous factor solutions found in the literature in this sample and determine whether additional psychometric exploration is needed.

1.4. Ethnic identity and OCD severity

In non-clinical samples, racial differences explained the over endorsement of contamination concerns in African Americans (Williams and Turkheimer, 2007), thus it is possible that ethnicity may be a factor in the current study. It would be incorrect to assume that such differences are caused by biological differences or an abstraction called "race" (Helms et al., 2005). Ultimately, differences are caused by some psychological or cultural variable associated with race (e.g., Williams and Turkheimer, 2007). Race and ethnicity can be problematic variables in research, as terms may have different meanings in different situations. In the US, where this study was conducted, African American (Black) and European American (White) racial groups are also synonymous with those corresponding ethnic and cultural groups.

A secondary interest of this study is to examine the relationship between ethnic identity and OCD severity in this population. Ethnic identity can be thought of as a sense of commitment and belonging to an ethnic group, positive feelings about the group, and behaviors that indicate involvement with the ethnic group (Phinney, 1992; Roberts et al., 1999; Avery et al., 2007). Ethnic identity is generally stronger and more salient among African Americans and other ethnic minorities than among European Americans, who tend to view Whiteness as normative (Phinney, 1992; Roberts et al., 1999; McDermott and Samson, 2005).

Previous studies have found that ethnic identity is negatively correlated to psychopathology severity among African Americans (Walker et al., 2008; Yip et al., 2006; Williams et al., 2012a). In their comprehensive review of anxiety psychopathology in African Americans, Hunter and Schmidt (2010) advance that ethnic identity may be a protective factor, buffering individuals from the negative concern over not being able to determine if high scores on this subscale represent distress over involvement in resistance/control or lack thereof.

1.3. Properties of the Y-BOCS In African Americans

Only two studies have examined the psychometric properties of the Y-BOCS in African Americans, utilizing samples of undergraduates and community participants (Washington et al., 2008; Garanat and Norton, 2010). Both of these studies used the self-report version of the Y-BOCS. Washington et al. (2008) found that a one-factor solution best characterized the structure of the Y-BOCS in the African American sample. However, the non-clinical undergraduate sample, even though it was very diverse, may be more homogenous than a clinical community sample. Further, Garanat and Norton (2010) explored the factor structure of the Y-BOCS among four different ethnic groups and concluded that comparisons between African American and European American participants might not be appropriate for the Obsessions subscale. Results showed that the Y-BOCS may underestimate obsessions in African Americans who endorse low to average levels of obsessions. No specific statistics were conducted for models using only African Americans in this study.
consequences of mental illness by facilitating social support, self-esteem, and religiosity. These are thought to comprise nonspecific protective factors that mitigate the development of anxiety psychopathology. However, no study to date has examined the relationship between ethnic identity and OCD severity in a clinical sample. We hypothesize that ethnic identity will be negatively correlated with OCD severity in African Americans.

2. Methods

2.1. Participants

Eighty-three African American participants were recruited for a study of African Americans with OCD at the Center for the Treatment and Study of Anxiety at the University of Pennsylvania. Of these, 75 were determined to have a diagnosis of lifetime OCD (71 with current OCD and 4 with subclinical OCD that met criteria for a diagnosis in the past). Participants were recruited via advertisement, clinical referral, and community outreach. Of these, 44% were male, with a mean age of 41.4 (S.D. = 12.2). The study was approved by the institution’s IRB and all participants provided informed consent. Inclusion criteria included: (1) age 18–70, (2) diagnosis of OCD, and (3) ethnicity of African American. All participants determined the diagnosis of OCD using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First et al., 2002) and clinical interview.

2.2. Evaluators

Cultivation of trust is an important factor, therefore whenever possible African American evaluators were used to create a comfortable and familiar environment where participants could feel at ease (Hatcher et al., 2000). Because some research has indicated that patients may be uncomfortable in a university-setting (Williams et al., 1997, Williams et al., 2013), evaluators were therapists who were practicing in the local community. All community evaluators received extensive training before assessing study participants, observing a minimum of two OCD evaluations conducted by the PI and conducting two study evaluations with the PI present before being considered trained for the purpose of this study (Williams et al., 2012c). Evaluators attended reliability meetings regularly, a training workshop about assessment and treatment of OCD, and met regularly with the PI for study supervision.

Although five African American evaluators were hired for this study over the recruitment period, there were also two university-affiliated European Americans who were trained as evaluators to assess participants when the community evaluators were unavailable. Of the 75 participants with lifetime OCD, five assessments were conducted by the European American evaluators, and one was conducted by a team consisting of one European American and one African American evaluator. The remaining assessments were conducted by African American masters or doctoral-level evaluators. Details about the recruitment and evaluation process are described elsewhere (Williams et al., 2012c).

2.3. Measures

The following measures were utilized for this study as part of a larger battery.

2.3.1. Yale-Brown Obsessive Compulsive Severity Scale

The Y-BOCS (Goodman et al., 1989a, 1989b) was administered to participants by a clinician to assess the severity of OCD symptoms. The scale consists of 10 items, each rated from 0 to 4, with the first five items addressing obsessions and the remainder focused on compulsions. Suggested cutoffs for severity designate OCD symptoms ranging from subclinical to extreme. The Y-BOCS demonstrated good internal consistency in this sample (α = 0.83). Prior to receiving the severity scale, all participants were administered the Y-BOCS checklist to identify specific obsessions and compulsions. The results from the checklist have been analyzed within their cultural context and findings are reported elsewhere (Williams et al., 2012b).

2.3.2. Beck Anxiety Inventory

The BAI (Beck, 1990) is a widely used self-report instrument designed to discriminate anxiety from depression in individuals. The scale consists of 21-items, each describing a common symptom of anxiety, and has good internal consistency and factor structure in African Americans (Chapman and Woodruff-Borden, 2009; Chapman et al., 2009). It was included to assess the divergent validity of the Y-BOCS. The BAI demonstrated excellent internal consistency in this sample (α = 0.93).

2.3.3. Beck Depression Inventory-II

The BDII (Beck et al., 1996) is a 21-item self-report measure of depressive symptoms. It has been shown to have good psychometric properties in African Americans (Dutton et al., 2004). It was included to assess the divergent validity of the Y-BOCS. The BDII demonstrated excellent internal consistency in this sample (α = 0.93).

2.3.4. The Clinical Global Impression Scale

The CGI (Guy, 1976) was used to rate the participants’ overall level of psychopathology, severity from OCD symptoms only. This was determined by the evaluator and reported on a Likert-type scale from 0–7, with higher scores related to greater severity. It was included to assess the convergent validity of the Y-BOCS.

2.3.5. The Global Assessment of Functioning

The GAF (American Psychiatric Association, 2000) is a scale from 0–100 used to rate subjective levels of functioning of individuals across different dimensions (e.g., psychological). Lower numbers correspond to poorer functioning. It was included to assess the convergent validity of the Y-BOCS.

2.3.6. Multigroup Ethnic Identity Measure

The MEIM (Phinney, 1992) is a self-report measure of positive ethnic identity, which is suitable for use with any ethnic group. The scale employed was the 12-item revision by Roberts et al. (1999), originally validated in adolescents of various ethnic groups. The MEIM has also been validated in a nationally representative sample of African American and European American adults, ages 18–35, with excellent reliability (α = 0.91; Duque et al., 2011). Typical items include questions like, “I feel good about my cultural or ethnic background,” and “I participate in cultural practices of my own group, such as special food, music, or customs.” In the current study, items were scored from 1 to 4, with higher numbers corresponding to greater agreement (α = 0.86). It was included to assess the relationship between ethnic identification and severity of psychopathology.

2.4. Statistical methods

Pearson correlations were used to explore the relationship between the Y-BOCS and other measures. A series of CFA’s were conducted to evaluate the fit of previously demonstrated factor structures of the Y-BOCS (Fig. 1) using data from the current sample. The CFA’s were performed with AMOS 18. The size of the sample is not optimal for CFA’s but research supports the applicability of CFA’s in samples of this size (iacobucci, 2010). Moreover, the simplicity of the proposed models (e.g., no indirect effects, limited number of latent variables), the reliability of the Y-BOCS, and the strength of the communalities between the observed variables facilitate the use of CFA’s with this sample (iacobucci, 2010). Fit for each model was compared to the following fit criteria with 90% confidence intervals (when applicable): (1) chi-square (value should not be significant), (2) chi-square/df. ratio (value should be less than 2.0), (3) Comparative Fit Index (CFI; value should be greater than 0.95), (4) Root Mean Square Error of Approximation (RMSEA; value should be less than 0.07), and (5) Expected Cross-Validation Index (ECV; lower values indicate a closer fit; Browne and Cudeck, 1989, 1993). Results approaching these values may be considered acceptable because fit indices are often minimized with smaller samples (Fan et al., 1999). When the CFA’s suggest that none of the previously demonstrated factor structures exhibit good or excellent fit, a maximum likelihood EFA with oblique rotation (Costello and Osborne, 2005) followed the CFA’s as means to determine if a new factor structure is best appropriate for the current data (Schmitt, 2011). The number of factors retained from this EFA was based on Cattell’s scree test and on the number of factors with an eigenvalue over one. To investigate the role of these factors and ethnic identity in OCD psychopathology, linear regression was subsequently used to predict total CGI score based on OCD factors and ethnic identity. These analyses were conducted using SPSS, version 20.

3. Results

3.1. Means and correlational findings

Based on mean scores, the sample was, on average, in the clinical range for OCD severity (Y-BOCS, M = 22.88, S.D. = 6.78), had elevated levels of anxiety (BAI, M = 28.16, S.D. = 14.39) and depression (BDII, M = 23.9, S.D. = 12.67), and demonstrated global impairments based on the CGI (M = 4.07, S.D. = 1.12) and GAF (M = 60.72, S.D. = 11.83). Regarding OCD severity, 13% were in the subclinical range (n = 1; Y-BOCS = 0–7), 12% in the mild range (n = 9; Y-BOCS = 8–15), 34.7% in the moderate range (n = 26; Y-BOCS = 16–23), 41.3% in the severe
range ($n = 31$; Y-BOCS = 24–31), and 10.7% in the extreme range ($n = 8$; Y-BOCS = 32–40). We also assessed ethnic identity, using the MEIM ($M = 38.30$, S.D. = 6.49), which is comparable to findings in non-clinical African American adult samples (e.g., $M = 39.42$, S.D. = 5.50; Williams et al., 2012a).

Correlations between all measures are reported in Table 1 to examine convergent and divergent validity. The Y-BOCS was significantly correlated to the CGI and GAF in the expected directions. The relationships were stronger than the correlations to the BDI-II and the BAI (which were not significant), supporting the convergent validity of the Y-BOCS. Correlations between each item on the Y-BOCS and the total score (minus the item in question) ranged from 0.50 to 0.75 (Table 2).

## Table 1

<table>
<thead>
<tr>
<th></th>
<th>1-Y-BOCS</th>
<th>2-BAI</th>
<th>3-BDI-II</th>
<th>4-CGI (OCD only)</th>
<th>5-GAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-BAI</td>
<td>0.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-BDI-II</td>
<td>0.09</td>
<td>0.40**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-CGI (OCD only)</td>
<td>0.50**</td>
<td>0.12</td>
<td>0.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-GAF</td>
<td>-0.24†</td>
<td>0.18</td>
<td>-0.36**</td>
<td>-0.30**</td>
<td>0.321**</td>
</tr>
</tbody>
</table>

Y-BOCS = Yale-Brown Obsessive Compulsive Severity Scale; BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory 2; CGI = Clinical Global Impression Scale; GAF = Global Assessment of Functioning; OCD = Obsessive-Compulsive Disorder; MEIM = Multigroup Ethnic Identity Measure.

† $p < 0.05$.
* $p < 0.01$.
** $p < 0.001$.

## 3.2. Confirmatory factor analyses

Fit indices from the CFAs testing the five previously demonstrated factor structures are reported in Table 3. Standardized regression factor loadings for each of the items within each of the models are reported in Fig. 2. The three-factor model demonstrated by Moritz et al. (2002) exhibited best fit across all fit indices compared to other models and was the only model to exhibit marginally acceptable fit (i.e., CFI approximating 0.90 and RMSEA approximating 0.10; Hu and Bentler, 1999). None of the...
models exhibited good or excellent fit, and, as such, EFA were conducted to explore if a novel solution is best supported by the current data. The results of the EFA supported either a one-factor solution (42% of variance) or a three-factor solution (68% of variance; five first eigenvalues = 4.23, 1.33, 1.25, 0.77, 0.59), as discerned by eigenvalues over the value of one and Cattell's scree test. The CFAs previously demonstrated that a one-factor solution produces inferior fit compared to other solutions; consequently, a three-factor solution was interpreted (Table 4).

The pattern of factor loadings was consistent with those reported by Moritz et al. (2002), and thus corroborated the results from the CFAs. As observed in Table 4, the factor loadings yield a three-factor solution representing three subscales including (1) Severity of Obsessions, (2) Resistance, and (3) Severity of Compulsions. The Severity of Obsessions factor included four items assessing the time, interference, distress, and control related to OCD obsessions. The Resistance factor is composed of two items related to resistance to OCD obsessions/compulsions. Finally, the Severity of Compulsions factor included four items related to time, interference, distress, and control of OCD compulsions.

3.3. Predictors of clinical global impressions

Pearson correlations indicated that all three factors and ethnic identity were significantly correlated to the CGI ($r_{\text{Factor1}} = 0.42$, $p < 0.001$; $r_{\text{Factor2}} = 0.34$, $p = 0.005$; $r_{\text{Factor3}} = 0.55$, $p < 0.001$.)
Y-BOCS predicting CGI from each of the three Y-BOCS dimensions identified in the EFA and ethnic identity. The overall model was significant (F[66]=10.19, Adj R²=.036, p<0.001), with Factor 3 (Severity of Compulsions, t=3.76, beta=0.448, p=0.001) and ethnic identity (t=−2.42, beta=−0.259, p=0.019) making significant contributions.

4. Discussion

4.1. Indicators of convergent validity

The primary purpose of the present study was to determine the psychometric properties of the Y-BOCS in an African American sample. We found that the total scores for the Y-BOCS have positive relationships with levels of psychopathology severity rated by trained evaluators. Moreover, Y-BOCS total scores in this sample also showed a significant negative relationship with observed ratings of functioning in individuals. Thus, high levels of scores in the Y-BOCS are strongly related to low levels of global functioning in individuals.

4.2. Indicators of divergent validity

Furthermore, the Y-BOCS did not have significant relationships to the BDI-II nor the BAI, demonstrating that it is likely measuring distinct obsessive-compulsive constructs, rather than depression or general anxiety symptoms, which both tend to co-occur with OCD (Ruscio et al., 2010). These findings may be somewhat inconsistent with previous research that has demonstrated that Y-BOCS total scores share significant relationships with other psychopathology severity scales like the BDI, Deacon, and Abramowitz (2005), obtained significant relationships between these two scales, and other scales related to impairment caused by OCD. However, the authors made use of a two-factor solution of the Y-BOCS, and the subscales demonstrated problems with discriminant validity. In fact, a previous study, using a similar two-factor model also obtained significant correlations between the BDI and the two subscales of obsession and compulsion severity (McKay et al., 1995). Nevertheless, studies generally do not find correlations between BAI and Y-BOCS scores.

4.3. Comparisons of Y-BOCS total scores to similar studies

Several studies to date have not described the ethnic composition of their samples (Amir et al., 1997; McKay et al., 1995) or have primarily included European or European American participants (Fals-Stewart, 1992; Moritz et al., 2002; Deacon and Abramowitz, 2005). In comparison to our sample, comprised of only African American participants, we observe a slightly lower mean severity score of 22.9 (S.D.=6.8) in the Y-BOCS, as compared to other two studies with mostly European American participants obtaining mean scores of 24.0 (S.D.=5.4; Deacon and Abramowitz, 2005) and 23.5 (S.D.=6.4; Moritz et al., 2002). It is possible that the lower mean scores represent some underestimation of symptoms among African Americans, as suggested by Garnaat and Norton (2010). Further research should look into how differences in scores may relate to cross-cultural psychometric differences in the Y-BOCS.

4.4. Comparisons of model fit

The relationships between individual Y-BOCS items and the total score were similar between items and suggest that the items are assessing generally the same construct. However, the resulting factor structure of the present sample was consistent with the three-factor one presented by Moritz et al. In our model, the resistance items form their own factor, and the control items (items 5 and 10) each load into their respective obsession/compulsion factors. Moritz et al. (2002) expressed some concern in seeing the control items (items 5 and 10) loading into the resistance factor, but still obtained conclusive results of each one loading best in the obsession or compulsion factors. In contrast, Deacon and Abramowitz (2005) presented two new factors, one referring to severity of obsessions/compulsions as one, and a factor composed of resistance and control items. The factors found in our African American sample provided more clarity as to where each item loaded, with the resistance items (4 and 9) loading together to form a factor. Nevertheless, studies have found that these resistance items (4 and 9) present difficulties in how ambiguous their presence is within an individuals’ global OCD severity (Kim et al., 1994; Deacon and Abramowitz, 2005; Garnaat and Norton, 2010). Much like in these studies, the current study found these two items represented the lowest factor loadings of all items. Deacon and Abramowitz (2005) explained that these two items do not present a clear idea of an individual’s OCD severity. High scores obtained can both mean that the person is highly involved in resisting the obsessions or compulsions, but they may also have high scores as they are able to control or resist them by not engaging in them. Therefore, the validity of such items in the questionnaire may be in question, as they may increase the possibility of underestimating symptom presentation related to OCD in individuals. However, in Garnaat and Norton’s (2010) study of cross-cultural differences between European American and African American participants, we observe that the contrast could only be done in the community sample as opposed to the clinical sample. The community sample may have presented low levels of severity, which compared to our sample may give a different factor structure or overall invariance if the sample was moderately severe or clinical in nature.

Furthermore, the third factor (Severity of Compulsions) in our model of the Y-BOCS was the most predictive of CGI within the sample. This is congruent with the idea that compulsions represent a more action-driven activity that individuals may engage in as part of their disorder. The CGI may recognize these actions as representing greater psychopathology in an individual.

4.5. OCD severity and ethnic identity

A secondary goal of this study was to explore the relationship between OCD severity and ethnic identity. Our results did not show a relationship between ethnic identity and the self-reported symptom measures, which differed from findings in a non-clinical sample (Williams et al., 2012a). However, ethnic identity did correlate significantly with clinician-rated OCD impairment and

| Item-level factor loadings resulting from exploratory factor analysis. |
|---------------------|---------------------|---------------------|
| Factor 1 | Factor 2 | Factor 3 |
| Y-BOCS 1 | 0.71 | −0.17 | 0.00 |
| Y-BOCS 2 | 0.64 | 0.17 | 0.06 |
| Y-BOCS 3 | 0.69 | 0.11 | 0.12 |
| Y-BOCS 4 | 0.27 | −0.64 | −0.13 |
| Y-BOCS 5 | 0.68 | −0.31 | −0.06 |
| Y-BOCS 6 | 0.33 | −0.11 | 0.50 |
| Y-BOCS 7 | 0.30 | −0.07 | 0.38 |
| Y-BOCS 8 | 0.03 | −0.02 | 0.76 |
| Y-BOCS 9 | −0.19 | −0.77 | 0.32 |
| Y-BOCS 10 | 0.00 | −0.01 | 0.71 |

Y-BOCS= Yale-Brown Obsessive Compulsive Severity Scale; values over 0.35 are in bold.

$r_{EthnicIdentity}=-0.31, p<0.001$. We conducted a regression predicting CGI from each of the three Y-BOCS dimensions identified in the EFA and ethnic identity. The overall model was significant (F[66]=10.19, Adj R²=.036, p<0.001), with Factor 3 (Severity of Compulsions, t=3.76, beta=0.448, p=0.001) and ethnic identity (t=−2.42, beta=−0.259, p=0.019) making significant contributions.
global functioning overall. This provides some evidence that ethnic identity may be an important buffer against illness severity in this population, helping to stave off the harmful effects of discriminatory experiences that may otherwise lead to greater psychological distress (Franklin-Jackson and Carter, 2007; Hunter and Schmidt, 2010). Stress is a mitigating factor in psychopathology broadly, and it could be that ethnic identity protects against OCD symptoms and overall psychopathology by reducing race-related stress. For example, Soto et al. (2011) found that experiencing racial discrimination was associated with significantly higher odds of lifetime generalized anxiety disorder among African Americans.

4.6. Study limitations

There are a few limitations to the current study. The cross-sectional nature of our study does not allow us to state the directionality of the relationship between ethnic identity and OCD impairment. Our sample only represents a specific population recruited in a specific period of time. The possibility of observing if these results are stable across time and place should increase the validation of the measure and the presently described three-factor structure. Therefore, further research is needed to explore the psychometric properties and validation of the Y-BOCS with other ethnoracial minorities with OCD. The inclusion of a culturally sensitive scale may shed light as to how these variables may relate to the presentation of OCD and severity. Moreover, longitudinal or between samples designs may help in furthering the validation of the Y-BOCS and this factor structure in understudied samples within this line of research. The sample was relatively small for this study and future studies may benefit from a sample size in line with classical recommendations for factor analyses (e.g., over 100 cases; MacCallum et al., 2001). Nevertheless, the present sample allowed appropriate comparison of model fit and generated an exploratory factor structure convergent with our results and those from other studies.

5. Conclusion

This study represents an important contribution to the psychiatric literature as it is the first to examine the Y-BOCS severity scale in African Americans with OCD, Overall, we find that the Y-BOCS has good psychometric properties and appears to be a valid and sensitive scale for use in African American populations (PI M. Williams).

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References


