

OCD in Ethnic Minorities

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Received 25 Dec 2019; **Accepted** 11 Feb 2020; **Published** 18 Feb 2020

Abstract

This study explored symptomology and treatment seeking behavior of ethnic minority groups with obsessive-compulsive disorder (OCD). Results indicated minorities were more likely to endorse the magical/superstitious OCD symptom category compared to non-minorities. While severity and disability levels among all populations for OCD were similar, treatment was alarmingly different. Non-minorities were more likely to receive general counseling (2.09 times), ERP (1.86 times) and to be currently taking medications (1.51 times) than minorities who were 2.00 times more likely to have never taken medication. Our findings indicate that minorities with OCD are under-treated and underserved regarding both psychological and psychiatric services.

Keywords: OCD • Ethnic minorities • OCD severity • Access to care • Disparities

Introduction

Obsessive compulsive disorder (OCD) is a chronic, debilitating mental health disorder characterized by recurrent and intrusive thoughts or images that cause anxiety (obsessions), followed by repetitive and ritualistic behavior (compulsions) aimed at reducing the resulting anxiety [1]. For individuals with OCD, obsessions and compulsions can consume many hours in the day [2], and can greatly impair and interfere with daily functioning [3,4]. In the United States, OCD is the fourth most common psychiatric illness subsequent to phobias, depression, and substance abuse [5] and affects 2% of the global population [6], which translates to approximately 6-9 million Americans diagnosed [7]. It can take up to 9 years for a person with OCD to receive an accurate diagnosis, and up to 17 years to obtain effective treatment [8]. Although effective treatment exists, individuals often receive unvalidated forms of intervention [9] despite the availability of effective behavioral and pharmacological interventions [10].

Providing exposure and response prevention therapy either alone or in combination with serotonin reuptake inhibitor medications are efficacious treatments for individuals with OCD [10]. Although initial research suggests prevalence rates across ethnicities, ethnic minorities with OCD are under-represented across research and clinical settings despite preliminary findings that indicate treatment is as effective in ethnic minority groups as it is in the majority ethnic group [11-13]. Currently, few studies examine treatment outcome for minorities with OCD [11,12], calling into question whether ethnic minorities are treated in the same manner as European Americans [14]. For

example, a North American review of 21 clinical trials of OCD from 1995-2008 reported ethnicities as 91.5% European Americans, 1.6% Asian, 1.3% African American, 1.0% Hispanic, 1.5% as Other, and 3.1% as Unknown [11]. A separate study examining the prevalence and impact of OCD among African Americans and Caribbean blacks revealing only 20% to receive specialized mental health treatment, and 20% report using SRI medication to treat their OCD symptoms [15]. Similarly, the DSM-IV field trial of patients from five OCD specialty clinics within the United States only includes 5.4% of patients from ethnic minorities [16], revealing the low number of minorities engaging in treatment. Overall, ethnic minorities are less likely to seek treatment for OCD than their white counterparts [14].

Though findings for this treatment disparity are limited, financial barriers, language barriers, proximity to specialty clinics, cultural beliefs about mental illness and mistrust of the larger medical system may contribute to reduced service utilization [11, 17]. There may be more than one barrier as the cause of not receiving or seeking treatment for OCD with ethnic minorities. Other barriers for treatment include a lack of knowledge about where to find treatment, concerns over discrimination, fears of therapy, beliefs that the clinician will not be able to help, and feelings that treatment is not warranted [14]. Many endorse cultural mistrust, discrimination concerns, and concerns about culture and values as challenges for ethnic minorities in obtaining mental health services [18]. Additionally, environmental stressors constitute an increased possibility for individuals to cope with mental health in negative and destructive ways. It is less likely for individuals to be seeking appropriate mental healthcare if they are living in poverty, dangerous neighborhoods, or in other stressful environmental situations [19]. Making OCD mental health services and all other mental health services more readily available may help address the burden of these mental health disparities.

OCD is a heterogeneous disorder; therefore, it is important to consider ethnic group differences regarding symptomology in order to alleviate misdiagnosis [14, 20]. Research suggests African Americans are more likely to report higher rates of contamination-related symptoms and cleaning rituals than European Americans [21-23]. However, these numbers do not account for misdiagnosis or lower preference for participation in treatment decisions associated with African Americans [24]. Latino Americans and Asian Americans also report higher contamination symptoms compared to European Americans [25]. It is imperative that symptomology and presentation are fully assessed and examined across cultures to effectively treat all populations with OCD.

Additional research is warranted regarding access to care with non-minority groups as well as further exploration of minorities symptomology and presentation of OCD. The aim of this study is to better understand the differences in OCD symptomology across ethnic groups and evaluate OCD treatment seeking behavior within ethnic minority groups. It is hypothesized that OC symptom presentation will differ among ethnic minority groups compared to non-minority groups and that treatment seeking behaviors will significantly differ. We hypothesize that minority groups will be less likely to seek OCD specific treatment (ERP) than non-minority groups. Understanding the differences in symptomology and OCD treatment among minority groups can directly impact education, assessment, treatment and relapse prevention. Further assessing these differences may warrant the addition of increased novel cost-effective treatment options for ethnic minorities with OCD. The present study seeks to broaden practitioner knowledge to help maximize treatment outcomes with minority populations.

Method

Secondary data from The OCD Challenge (ocdchallenge.org/com), a free self-help website designed and developed in 2011 to serve as an easily accessible tool for managing one's OCD [26], is used for this study. Data collection procedures were approved by the institutional review board (IRB). Standard website recruitment for the OCD Challenge program was used, and specific recruitment for this study did not take place. Standard website recruitment includes online searching, OCD conference announcements, social media, OCD clinician referrals, etc. Website users sign up to use the OCD Challenge website voluntarily without any compensation. Website users who accepted the terms of agreement (i.e., consenting for their data to be used for research), and completed some or all of the following assessments (demographics, OCD symptom categories measure, the initial assessment of the Yale-Brown Obsessive Compulsive Scale, (Y-BOCS) [27], the Sheehan Disability Scale (SDS) and the DASS) were included in this study. Users voluntarily completed the assessments as part of standard use of the OCD Challenge website. User data from participants who had completed assessments included in this study was analyzed.

Measures

Multiple demographic questions were administered through the OCD Challenge website and were used. Demographics included age, gender, ethnicity, website referral, religious affiliation, age of onset of OCD symptoms, perceived OCD severity levels, and OCD treatments accessed. Ethnic minorities for this study are defined as individuals who self-selected as being part of a treatment seeking ethnic minority group including Asian/Pacific Islander, Hispanic, Latino, Black and Multiracial. Perceived OCD severity level (listed as self-rating in Table 1) is a single-item self-rated measure

[28] where participants are asked to rate their OCD severity by selecting a response with the following options: mild, moderate, severe, extreme, or would rather not say. OCD categories were selected by individual users and various formal assessments were administered through the website. The treatment accessed was self-reported and included treatments such as ERP, medication, and general counseling (Table 2).

OCD symptom categories are listed as challenge areas within the OCD Challenge website. The symptom categories identified within the website include Contamination, Harm to self, Harm to others, Scrupulosity/Morality, Not Just Right, Sexual Thoughts, Somatic, and Magical/Superstitious. Individuals can select one or multiple OCD symptom categories that pertain to their OCD symptomology by selecting "Yes" to one of the questions listed under every symptom category. Examples of questions found in the magical/superstitious symptom category of OCD include: (1) Do you have excessive concerns about certain numbers (lucky/unlucky) or words? (2) Do you worry excessively about breaking a superstitious belief that will then cause something bad to happen?

The Y-BOCS (Yale-Brown Obsessive Compulsive Scale) [27] is a validated OCD measurement used to assess OCD severity levels through 10 questions divided into two categories, five questions focused on obsessions and five on compulsions. Total Y-BOCS scores are then used to measure severity with five severity ratings: sub-clinical (0-7), mild (8-15), moderate (16-23), severe (24-31), and extreme (32-40). Website users' scores from their first Y-BOCS completed was used in this study. Reliability of the Y-BOCS within our sample was excellent with a Cronbach's alpha of 0.91.

The Sheehan Disability Scale (SDS) [29] measures disability levels in work/school, social and family life through three questions. Initial SDS output scores of users was used to evaluate disability levels among individuals

Table 1. Comparison of severity between minority and non-minority participants.

		M(SD)	Cohen's d	F	P
Self-Rating	Minority	2.59 (0.82)	0.02	0.088	0.767
	Non-Minority	2.61 (0.84)			
DASS Anxiety	Minority	7.32 (5.53)	0.26	6.098	0.014
	Non-Minority	6.07 (4.25)			
DASS Stress	Minority	10.44 (5.42)	0.01	0.008	0.93
	Non-Minority	10.40 (4.52)			
DASS Depression	Minority	8.64 (5.92)	0.01	0.003	0.959
	Non-Minority	8.67 (5.86)			
Sheehan	Minority	18.00 (7.68)	0.01	0.016	0.899
	Non-Minority	17.82 (7.20)			
YBOCS	Minority	24.00 (7.86)	0.16	2.737	0.099
	Non-Minority	25.19 (6.94)			

Table 2. Comparison of treatment between minority and non-minority participants.

		Non-Minority (n)	Minority (n)	Chi Square (χ ²)	P
General Counseling	Endorsed	116	75	14.769	0
	Not Endorsed	114	154		
ERP	Endorsed	62	38	7.36	0.007
	Not Endorsed	168	192		
Current Therapy	Endorsed	87	73	1.788	0.181
	Not Endorsed	143	156		
Current Medication	Endorsed	102	79	4.662	0.031
	Not Endorsed	128	150		
Have Taken Medication	Endorsed	73	60	1.71	0.191
	Not Endorsed	157	169		
Never Taken Medication	Endorsed	38	65	9.278	0.002
	Not Endorsed	192	164		

within our sample of minority and non-minority status. Reliability of the SDS within our sample was good with a Cronbach's alpha of 0.85.

The Depression Anxiety and Stress Scale 21 (DASS) [30] was used to assess depression, anxiety, and stress. Initial output scores from this 21-item measurement tool were used for this study to determine levels of depression, anxiety, and stress of participants. Research has shown the DASS to have strong predictive and discriminant validity as well as both internal consistency and temporal stability [31]. Anxiety and distress are indicators of an OCD diagnosis [32]. The DASS is a helpful and reliable measure used in many OCD research studies to determine comorbid anxiety disorders (i.e. panic disorder, specific phobias, generalized anxiety) and depression [31]. Reliability of the DASS within our sample was excellent with a Cronbach's alpha of .93. More specifically, the Cronbach's alpha for the stress subscale was 0.83, the anxiety subscale was 0.83 and the depression subscale was 0.89.

Participants

The present study included 460 participants ranging from 18 to 68 years of age (M=30.80, SD=10.05). The sample was slightly skewed toward female (61.3%), and half the participants (50.3%) identified as Caucasian/White followed by Asian/Pacific Islander (20.1%), Hispanic (9.6%), Latino (5.9%), Black (5.7%), and Multiracial (5.5%). The majority of participants identified as Non-Catholic Christians (30.6%), followed by Catholic (21.3%), and non-religious (19.1%). Given the OCD Challenge website is offered around the world and in several languages, participants were also identified by location. Most participants were located in North American (n=322; 70.0%) followed by Asia (n=59; 12.8%), Europe (n=53; 11.5%), Australia (n=13; 70.0%), South America (n=10; 2.8%), and Africa (n=3; 0.7%).

All participants in the present study self-identified with OCD symptoms and visited the OCD Challenge website. The self-reported onset for OCD symptoms ranged from 0 to 66 years of age (M=17.37, SD=9.13). The most frequent method of referral via standard recruitment to the OCD Challenge website was the internet (25.8%), followed by Google (24.9%), the International OCD Foundation (16.2%), and a professional (16.6%).

Data analysis

Analyses were conducted using SPSS for windows, version 24. Propensity Score Matching (PSM) was utilized to match individual subjects from different groups based on a propensity score, or balancing score, so that the distribution of identified baseline confounds are similar among both groups [33,34] and group differences can be directly compared, increasing the probability that results are due to primary dependent variables rather than

baseline confounds [33]. Propensity score matching is popular in traditional medical research [35] and has recently gained popularity among psychiatric [36] and psychotherapy treatment outcome research [37-39]. In the present study, participants were matched on age, gender, and age of OCD onset. No significant differences were found between groups for the matched variables: gender [$\chi^2(1)=0.916$, $p=0.336$]; and age of OCD onset [$F(1,458)=0.063$, $p=0.803$]. There was a significant difference for age [$F(1,458)=4.155$, $p=0.042$] as non-minorities (M=31.75, SD=10.56) were slightly older than minorities (M=29.85, SD=9.45).

Next, a series of one way analyses of variance (ANOVAs) were calculated to determine if there were differences between participants identifying as ethnic minorities and those identifying as non-minorities on a series of continuous variables. Then, a series of Pearson's Chi Square Tests were conducted on categorical variables. Across analyses, no statistical correction was used given the relatively early nature of work examining OCD among minority populations.

Results

The first series of analyses looked to examine differences between participants who identified as ethnic minorities compared to those who identified as non-minorities on variables related to OCD severity, disability, and overall distress utilizing a one-way analysis of variance (ANOVA). Results on the DASS revealed that both groups scored in the moderate range on all three subscales. A significant difference emerged between groups on the anxiety subscale [$F(1,374)=6.098$, $p=0.014$] as minorities experienced more anxiety (M=7.32, SD=5.53) than non-minorities (M=6.07, SD=4.25, $d=0.26$). There were no significant differences between groups for the other two subscales of the DASS: Stress [$F(1,374)=0.008$, $p=0.930$] and Depression [$F(1,374)=0.003$, $p=0.959$]. Further results revealed there were no significant differences between groups for the remainder of the variables measured (Table 1) suggesting that minorities and non-minorities experienced equivalent levels of OCD symptoms.

Next, we examined the categories of OCD. Results revealed a significant difference between participants identifying as ethnic minorities and those identifying as non-minorities for the Magical/Superstitious category [$\chi^2(1)=5.356$, $p=0.021$] as ethnic minorities were 1.74 times more likely to endorse this category of OCD. No other differences were found among categories of OCD (Table 3). The second series of analyses examined the differences between participants who identified as ethnic minorities compared to those who identified as non-minorities on variables related to treatment. Results revealed significant differences for both counseling not specific to OCD [$\chi^2(1)=14.769$, $p < 0.000$] and exposure and response

Table 3. Comparison of OCD Subtypes between minority and non-minority participants.

		Non-Minority (n)	Minority (n)	Chi Square (χ^2)	p
Contamination	Endorsed	84	86	0.691	0.406
	Not Endorsed	70	59		
Harm to Self	Endorsed	99	97	0.225	0.635
	Not Endorsed	55	48		
Harm to Others	Endorsed	92	91	0.287	0.592
	Not Endorsed	62	54		
Sexual Thoughts	Endorsed	68	68	0.062	0.803
	Not Endorsed	77	77		
Magical/Superstitious	Endorsed	51	67	5.356	0.021
	Not Endorsed	103	78		
Somatic	Endorsed	74	59	1.639	0.2
	Not Endorsed	80	86		
Scrupulosity	Endorsed	75	81	1.535	0.215
	Not Endorsed	79	64		
Not Just Right	Endorsed	133	128	0.246	0.62
	Not Endorsed	21	17		

Table 4. Comparison of OCD Subtypes between ethnic groups.

	Contamination		Harm to Self		Harm to Others		Sexual Thoughts		Magical / Superstitious		Somatic		Scrupulosity		Not Just Right	
	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>
Arab	0.64	0.424	0.001	0.976	0.032	0.857	0.533	0.465	0.941	0.332	0.144	0.704	2.822	0.093	0.449	0.503
Asian	0.81	0.368	0.004	0.952	0.109	0.741	0.221	0.638	3.61	0.058	1.538	0.215	0.314	0.575	0.168	0.682
Black	0.302	0.582	0.348	0.555	1.092	0.298	0.36	0.549	0.303	0.582	0.212	0.646	0.689	0.407	0.048	0.826
White	0.757	0.384	0.152	0.967	0.217	0.646	0.096	0.757	5.063	0.024	1.464	0.226	1.103	0.294	0.116	0.734
Hispanic	0.96	0.327	0.41	0.522	2.341	0.126	2.528	0.112	1.145	0.285	0.41	0.522	0.144	0.704	0	0.992
Aboriginal	0.137	0.711	1.416	0.234	0.032	0.857	3.61	0.058	4.666	0.031	0.144	0.704	2.822	0.093	0.449	0.503
Latino	0.27	0.603	0.078	0.779	0.372	0.542	3.61	0.058	0.13	0.719	0.24	0.624	0.144	0.704	0.533	0.465
Multiracial	0.593	0.441	0.005	0.944	0.014	0.905	0.212	0.646	1.082	0.298	0.548	0.459	3.96	0.047	0.004	0.952

Table 5. Comparison of treatment utilization between ethnic groups.

	General Counseling		ERP		Current Therapy		Current Medication		Past Medication		Never Taken Medication	
	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>	χ^2	<i>p</i>
Arab	0.26	0.61	3.686	0.055	0.384	0.535	1.02	0.313	1.44	0.23	0.563	0.453
Asian	9.548	0.002	4.162	0.041	8.066	0.005	0.23	0.631	3.534	0.06	0.462	0.497
Black	1.716	0.19	0.774	0.379	2.25	0.134	7.236	0.007	0.24	0.624	3.24	0.072
White	14.062	0	7.076	0.008	1.369	0.242	4.709	0.03	1.082	0.298	8.703	0.003
Hispanic	4.162	0.041	1.796	0.18	0.01	0.92	7.236	0.007	0.578	0.447	0.123	0.726
Aboriginal	0.462	0.497	0.029	0.865	1.681	0.681	2.161	0.142	4.121	0.042	1.88	0.276
Latino	0.01	0.92	0.865	0.352	0.449	0.503	0.026	0.873	0.672	0.412	1.769	0.184
Multiracial	3.648	0.056	0.476	0.49	0.017	0.897	0.593	0.441	0.102	0.749	2.56	0.11

prevention therapy [$\chi^2(1)=7.360, p=0.007$]. Non-minorities were 2.09 times more likely to receive general counseling and 1.86 times more likely to receive exposure plus response prevention. Significant differences were also found with regard to medication, for both participants reporting they are currently taking it [$\chi^2(1)=4.662, p=0.031$] and those who had never taken medication [$\chi^2(1)=9.278, p=0.002$]. Ethnic minorities reported they were 2.00 times more likely to have never taken medication than non-minorities, and non-minorities reported they were 1.51 times more likely to be currently taking medication. No significant differences were found for having taken medication at some point (Table 2).

Finally, we compared categories and treatment utilization by specific ethnic groups. Among OCD categories, there were significant differences for the Magical/Superstitious category among white [$\chi^2(1)=5.063, p=0.024$] and aboriginal participants [$\chi^2(1)=4.666, p=0.031$] (Table 4). For the Scrupulosity category there were significant differences for participants identifying as multiracial [$\chi^2(1)=3.960, p=0.047$]. More specifically, white individuals were 2.58 times less likely to endorse the Magical/superstitious category and participants identifying as multiracial were 3.11 times less likely to endorse the scrupulosity category. It was not possible to calculate odds ratios for the significant difference in the Aboriginal participants in the Magical/Superstitious category, as all participants endorsing this ethnicity endorsed this category.

For general counseling, there were significant differences for several ethnic groups including: Asian [$\chi^2(1)=9.548, p=0.002$], White [$\chi^2(1)=14.062, p=0.000$], and Hispanic [$\chi^2(1)=4.162, p=0.041$] (Table 5). More specifically, the participants who identified as white were 2.04 times more likely to endorse general counseling while Asian and Hispanic participants were 1.84 and 2.03 times less likely to report engaging in general counseling, respectively. Significant effects were found for ERP for both white [$\chi^2(1)=7.076, p=0.008$] and Asian [$\chi^2(1)=4.162, p=0.041$] participants. As such, white participants were 1.84 times more likely and Asian participants were 1.92 less likely to endorse using this mode of treatment. Finally, Asian participants were 2.12 less likely to endorse currently engaging in therapy [$\chi^2(1)=8.066, p=0.005$].

Medication use and history was also compared by ethnic group. Results revealed that white participants were 1.51 more likely to report current medication use [$\chi^2(1)=4.709, p=0.030$] while black [$\chi^2(1)=7.236, p=0.007$] and Hispanic [$\chi^2(1)=7.236, p=0.007$] participants were 3.96 and 2.74 times less likely to be presently receiving medication, respectively. Finally, Aboriginal participants were 7.43 times more likely to report taking medication in the past [$\chi^2(1)=4.121, p=0.042$] and white participants were 1.94 times less likely to report never having taken medication [$\chi^2(1)=8.703, p=0.003$].

Discussion

The present data further emphasizes the disparities that exist for ethnic minorities regarding access to effective OCD treatment despite similar OCD prevalence and symptomology as non-ethnic minorities [11,13]. No significant differences emerged regarding OCD severity levels among minorities in comparison to non-minority groups, indicating that both minorities and non-minorities groups have similar severity levels of OCD. Additionally, only one significant difference related to symptom categories of OCD; minorities were more likely to endorse the magical/superstitious symptom category of OCD compared to non-minorities within our sample. OCD symptom category findings from this study differ from others' regarding minorities and their obsessive compulsive symptoms. For example, current literature reports African Americans are often more likely to endorse contamination [21,22,23] whereas this finding did not hold within our population. This difference could be specific to a self-help cohort utilizing a web-based intervention or may be due to a self-identified cohort of individuals with OCD.

Cultural factors and stigma may contribute to higher prevalence of the magical/superstitious subtype of OCD within minority populations. Cultural factors including religious affiliations and cultural beliefs/norms may increase the likelihood of the magical/superstitious category of OCD. Obsessions and compulsions that align with this subtype of OCD may in fact be further reinforced by cultural and religious rituals and norms within minority populations compared to non-minority populations. Many OCD categories are associated with significant stigma; however, this type of OCD may be less stigmatizing than others, as many individuals in society

even without OCD may engage in superstitious/magical behaviors. Stigma is often a barrier associated with accessing mental health care [9], and may influence category selections via a self-help website. This category may be a less-stigmatized category of OCD and one that individuals of minority groups are more willing to endorse. Further research should be conducted to better understand the correlation between minorities and an increase in the magical/superstitious sub-type of OCD compared to non-minorities.

Major disparities exist regarding OCD treatment utilization with minorities compared to non-minorities. Within our sample, non-minorities were more likely to receive general counseling, ERP, and to be currently taking medications than minorities. Minorities were also less likely to have ever taken medication. Our results suggest that even though both groups report equivalent levels of severity and disability, with minorities reporting greater levels of anxiety, non-minorities are not receiving treatment at equivalent rates. These findings are consistent with previous research demonstrating an association between individuals' demographics (age, gender, race) and knowing where to access mental health treatment [24,40]. Other barriers that often prevent access to care include personal finances, stigma, geography, and a lack of information about the disorder and available treatment options [9,41,42]. Findings of the present study comport with extant literature that minorities are less likely to seek professional services due to concerns surrounding stigma and how help seeking may reflect on their family, as well as an additional desire to handle mental health problems internally. Similarly, minorities are more likely than non-minorities to utilize the church, feeling it is the only appropriate resource outside of the family [43], which is consistent with research that supported that African Americans with OCD preferred religious coping methods rather than seeking out mental health services and providers [44]. Overall, our findings further emphasize the importance of additional resources and culturally appropriate strategies to encourage engagement in evidence based treatment for OCD within minority populations. Increased education of mental health disorders and the efficacy of mental health treatment targeted specifically to minority populations is of high importance. Increased education can both reduce stigma and increase understanding and access to effective care available. One treatment strategy that warrants further exploration would be integrating evidence based mental health treatments into religious settings. This strategy may increase minorities willingness to engage in treatment by a stigma reducing method (offered in a safe place by trusted individuals) that is offered in a more accessible setting (congregations). Further exploration of obsessive compulsive symptom categories with minority groups utilizing various OCD intervention methods should be explored.

Limitations and Future Directions

Though significant findings exist surrounding minorities access to OCD treatment, limitations must be noted. By drawing attention to omissions in treatment for ethnic minorities, inclinations to create specialized care for minority treatment needs may increase. Our sample includes minorities from a self-help website who self-identify as having OCD. Obsessive compulsive symptoms/categories examined in this research were pulled from categories listed on the OCD Challenge website and may differ from current research regarding OCD categories. Future studies examining minorities with OCD should include a formal clinician administered assessment to formally diagnose OCD and should seek to further understand the reasons minority populations are not receiving/seeking adequate OCD care. For example, stigma may play a role in both seeking psychological services and engaging in psychiatric interventions versus the inability to access the care. Future studies should seek to better understand specific reasons for underutilization of care within minority populations and the increased prevalence of the magical/superstitious symptom category of OCD with minorities. Additionally, due to our small sample size further studies should explore these findings with a larger sample and across treatment seeking minority populations (self-help, outpatient, intensive outpatient and residential) in order to further evaluate findings from this study [45].

Conclusion

Even though severity and disability among minority and non-minority populations for OCD is the same, treatment is alarmingly different. Our findings indicate that minorities with OCD are undertreated and underserved,

with minorities less likely to have received both psychological and psychiatric services for their OCD diagnosis compared to non-minority groups. These findings warrant increased education and psychological/psychiatric services for OCD that are easily accessible to minority populations. Focused studies should further explore an understanding of this gap in accessing services that exists among minority populations as well as ways to counteract this disparity. Mental health practitioners who engage in counseling services should continue to increase their cultural competency to best serve minority populations with mental health diagnoses. The literature clearly indicates both a gap in services being accessed by minority groups and cultural barriers that negatively impact mental health treatment for this population. While evidence-based care for specific mental health conditions may span across all cultures the way it is both accessed and delivered should be tailored specifically to cultural/ethnic groups in order to increase treatment outcomes.

These findings warrant additional education and intervention options that are highly accessible including increased education, internet based care, free services and self-help interventions. In addition to the need for increased access to appropriate care for minority groups future research should focus on the effectiveness of standardized OCD treatment with minority groups including specialized intensive treatment for OCD. Effective treatment for an OCD diagnosis should be available to all despite ethnicity, economic circumstances or geographical locale. With the addition of web-based interventions and services in the mental health arena opportunities for increased access to care exists yet continues to be underutilized. These findings highlight the significant need for increased education and clinical services that are both accessible and utilized for OCD and other mental health conditions for minority populations.

Funding

This study was not funded by a grant.

Conflict of Interest

The authors declare that they have no conflict of interest. The authors approve consent for publication.

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