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INVITED PAPER

Cultural competency in the treatment of obsessive-compulsive disorder: practitioner guidelines

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Abstract

This article provides clinical guidelines for basic knowledge and skills essential for successful work with clients who have obsessive-compulsive disorder (OCD) across ethnic, racial and religious differences. We emphasise multiculturalist and anti-racist approaches and the role of culture in shaping the presentation of OCD in clients. Several competencies are discussed to help clinicians differentiate between behaviour that is consistent with group norms *versus* behaviour that is excessive and psychopathological in nature. Symptom presentation, mental health literacy and explanatory models may differ across cultural groups. The article also highlights the possibility of violating client beliefs and values during cognitive behavioural therapy (CBT), and subsequently offers strategies to mitigate such problems, such as consulting community members, clergy, religious scholars and other authoritative sources. Finally, there is a discussion of how clinicians can help clients from diverse populations overcome a variety of obstacles and challenges faced in the therapeutic context, including stigma and cultural mistrust.

Key learning aims

(1) To gain knowledge needed for working with clients with OCD across race, ethnicity and culture.
(2) To understand how race, ethnicity and culture affect the assessment and treatment of OCD.
(3) To increase awareness of critical skills needed to implement CBT effectively for OCD in ethnoracially diverse clients.
(4) To acknowledge potential barriers experienced by minoritized clients and assist in creating accessible spaces for services.

Keywords: cultural competency; diversity; ethnic minority; exposure and ritual prevention therapy; mental health disparities; obsessive-compulsive disorder; treatment outcomes

Introduction

This article is intended to provide guidelines surrounding basic competencies and skills that are essential for successful work with clients across ethnic, racial and cultural differences. It has been known for some time that minoritized groups have been under-represented as both mental health professionals and clients receive specialized care for obsessive-compulsive disorder (OCD) (e.g. Williams *et al.*, 2015a). Minoritized groups include Black, Indigenous and People of Colour (BIPOC) in the USA and Canada, and Black, Asian and Minority Ethnic (BAME) groups in the UK. In this article, these ethnoracially minoritized groups will be referred to as people of colour (POC). The seeds for this article were planted a few years ago when the International OCD Foundation brought together a diverse group of experts for the purpose of improving awareness, access and specialized clinical care for POC with OCD. This article was

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inspired by that initiative, developed to give voice to cultural knowledge specific to OCD, and to make important competencies and skills more accessible to the larger body of cognitive behavioural practitioners.

OCD is a severe, disabling disorder, characterized by the presence of obsessions and compulsions, where obsessions are unwanted and distressing thoughts, images or impulses, and compulsions are repetitive behaviours intended to reduce distress associated with obsessions. A person with OCD may suffer from a variety of symptoms; however, primary dimensions of OCD symptoms include contamination and cleaning, symmetry and ordering or arranging, doubts about harm and checking, and unacceptable thoughts and mental rituals (Williams *et al.*, 2013c).

People with OCD have heightened rates of other mental health disorders such as major depression, eating disorders, substance use disorders and anxiety-related disorders, as well as poor physical health (Himle *et al.*, 2008; Witthauer *et al.*, 2014). As such, they experience a lower quality of life across important functional domains such as leisure, relationships, work and educational activities. OCD is found across race, ethnic group and nationality, and it is estimated to afflict approximately one in sixty individuals over their lifetimes (Williams *et al.*, 2017b).

Western perspective

In directing ourselves towards a multiculturalist and anti-racist orientation, it is important to appreciate that these guidelines emanate from a primarily Western perspective. This means that the theoretical framework, explanatory models and research procedures undertaken to gain the knowledge provided herein follow from this frame of reference. It should be noted that other cultures may have different explanatory models with regard to mental health, and specifically OCD, and as such may not completely accept a cognitive behavioural therapy (CBT) conceptualization of how OCD is maintained or how to alleviate it.

It is essential that clinicians recognize that clients may be members of communities that are marginalized and stigmatized due to race, ethnicity, culture and/or religion. This means they experience discrimination, reduced opportunities and limited access to a society's resources, including medical care. This may pose additional difficulties that need to be addressed in treatment. Such clients may need more time to develop trust and rapport with a therapist, and may have additional fears about being stereotyped due to their unwanted OCD thoughts and behaviours (Williams *et al.*, 2017c).

Ethnic identity and acculturation

Ethnic identity is a multi-faceted construct that describes how people develop and maintain a sense of belonging to their ethnic heritage. Important factors influencing a person's ethnic identity include whether they identify as a member of an ethnic group, their sentiments toward their ethnic group, their self-perception of group membership, their knowledge and commitment to the group, and their ethnic-related behaviours and practices. Research shows that for minoritized individuals, a strong positive ethnic identity can provide resilience in the face of discrimination.

Another relevant and related construct is acculturation, traditionally defined as the extent to which people from different cultures adopt the values and participate in the traditional activities of dominant culture. Recent re-conceptualizations of the acculturation process utilize a multi-dimensional perspective, where minoritized individuals must reconcile discrepancies in their identities (ethnic *versus* national identity), value system (individualism *versus* collectivism), language proficiency, cultural attitudes and knowledge, and cultural practices (Chapman *et al.*, 2018). Acculturative statuses include strongly adhering to the mainstream culture and devaluing one's original heritage (assimilation), strongly adhering to the original heritage and devaluing the

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dominant culture (separation), and exhibiting little interest in adhering to either cultural stream (marginalization) (see Yoon *et al*., 2013). Biculturalism, or the ability of individuals to effectively integrate elements of two cultural streams, is thought to be one of the most protective acculturation statuses against negative health outcomes, despite high levels of minority stress (Chapman *et al*., 2018).

Aside from having knowledge of ethnic identity and acculturation, mental health professionals must also understand how these constructs interact to influence treatment-seeking and outcomes. In one popular model (Carter *et al*., 1996), minoritized people who maintain a strong ethnic identity and are highly assimilated in the dominant culture will endorse traditional beliefs of mainstream society (e.g. individualism) and exhibit symptom presentations consistent with Western diagnostic nomenclature. Notably, these individuals may believe psychological treatment is effective while maintaining some mistrust of societal systems in the dominant culture as a result of significant cultural experiences (e.g. racism and discrimination). Similarly, those low in ethnic identity yet highly assimilated will exhibit a traditional symptom presentation, but be more willing to seek, persist through, and benefit from traditional treatment practices. In contrast, individuals who do not identify with the dominant culture (separation or marginalization acculturation status) may display unique symptom presentations and utilize culturally specific explanations for their symptoms, thereby resulting in a greater likelihood for misdiagnosis. Furthermore, these individuals are less likely to seek treatment due to mistrust or limited knowledge of mental health care (Chapman *et al*., 2018).

Traditional healing practices

Many individuals utilize traditional healers to improve mental health, and it is not uncommon for individuals with OCD to enlist the support of spiritual and religious leaders. If the therapist believes that religion is causing or worsening the OCD, the therapist may try to control or suppress the person's beliefs to facilitate treatment. However, this may undermine trust and empathy, leading to conflict and drop-out. Therefore, whenever possible, therapists must work respectfully within the confines of the client's religious rules and traditions, which will ultimately facilitate treatment adherence. Indeed, the importance of culture is discussed in many psychological associations' ethics codes, including the American Psychological Association's (2017) *Ethical Principles of Psychologists and Code of Conduct*, the Canadian Psychological Association's (2017) *Canadian Code of Ethics for Psychologists*, and the British Psychological Society's (2018) *Code of Ethics and Conduct*. These codes underscore the requirement for psychologists to seek additional training, consultation and supervision when practising outside their scope of competence. The avoidance of harm is also a central principle and such harm may include disrespecting and violating a client's cultural and religious values. Clinicians must thus consider and integrate clients' values into the provision of OCD treatment.

Other than mainstream religions, there are also alternative healing practices that are connected to mental health, as many groups have introduced their approaches to health and wellbeing into Western culture through immigration and globalization. Often referred to as complementary and alternative medicine (CAM), these approaches may include Ayurveda, yoga, herbal medicine, acupuncture, Voodoo, astrology, Santeria, and new age therapies (Moodley and Sutherland, 2010), as well as traditional Chinese medicine (Liu, 1981), meditation (Neki, 1973) and/or shamanism (Metzner, 1998). Clinicians should be prepared to discuss the role of traditional medicine and CAM in the client's treatment. It is important to show respect for these systems and acknowledge indigenous, cultural and traditional healing practices, many of which are time-honoured methods that have been used to alleviate both physical and psychological problems for generations. When a conflict is experienced between a therapist and a traditional healer, it is advisable to collaborate with the healer rather than to force the client to make a

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choice between the two, as clients will generally choose their traditional healer over a mental health clinician (Pouchly, 2012).

Purpose of this article

The following competencies and skills are grounded in literature examining various ethnoracial groups' experiences of OCD or mental health, more generally. They have been selected through the authors' own empirical investigation, consultation with colleagues, and clinical experiences. While the findings may not apply to every client of colour, they may serve as a source of consideration for clinicians. This article assumes some basic skills in the ability to have conversations with clients about race, ethnicity and culture, but therapists who feel uncertain in their ability to comfortably navigate this can reference a number of good books and articles on this topic, tailored to the delivery of CBT (e.g. Beck, 2019; Williams, 2020; see also the 'Further reading' section at the end of this article). We emphasize that the underlying principles of reflection, respect, consultation and integration serve as the cornerstone of culturally competent and client-centred treatment. In addition, it is ideal for clinicians to demonstrate cultural humility through approaching other cultures with openness and respect, while prioritizing continual personal and professional growth (Hook *et al*., 2013).

Speciality knowledge

There are a number of areas where specialized knowledge is necessary to understand OCD across race, ethnicity and culture. The following sections describe the importance of knowledge in the areas of bias and culture, stigma, differences in symptom expression, the impact of discrimination, measurement issues, and treatment efficacy.

Awareness of personal biases and knowledge gaps

Some qualities that are integral to therapists effectively delivering treatment to minoritized clients include awareness of their own biases, awareness of gaps in knowledge about diverse clients they might serve, and awareness of how biases and gaps could negatively influence interactions with clients. Without being cognizant of personal biases and knowledge gaps, clinicians are more likely to overlook important cultural issues or fail to discuss them appropriately. It is not uncommon for therapists to ignore or change the subject when unfamiliar cultural issues arise or to proceed with interventions that are unacceptable to a client's cultural values (Chapman *et al*., 2018; Williams, 2020). Similarly, therapists may unknowingly convey insensitivity or disrespect through their words and actions, which may include statements about a person or their group in alignment with inaccurate or hurtful stereotypes (e.g. Williams and Halstead, 2019). Worse yet, therapists who have not worked to address their own prejudices may lash out at clients when their own biases are questioned.

Biases and gaps in cultural knowledge may also result in a lack of engagement in treatment and premature drop-out by clients. This underscores the need for effective and ongoing training in culturally sensitive care. When working with people from unfamiliar cultural groups, therapists should educate themselves on the client's culture. This may include consulting with community members or clergy, or seeking supervision with a knowledgeable clinician (Huppert *et al*., 2007; Williams *et al*., 2017c). Furthermore, adopting approaches to build rapport and improve the therapeutic relationship can be important, and one recommended behaviourally based interpersonal approach is functional analytic psychotherapy (FAP; Miller *et al*., 2015). The successful use of FAP has been described in detail as a useful supplement to exposure and ritual prevention (Ex/RP) in a case study of a Latino American with OCD (Wetterneck *et al*., 2012).

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Stigma and mental health literacy

Individuals from communities of colour experience greater mental health stigma, which reduces the likelihood of accessing mental healthcare (Turner *et al*., 2016; Williams *et al*., 2012b; Williams *et al*., 2017c). Stigma can be related to cultural concerns of bringing the family shame, being perceived as 'crazy' and being hospitalized, confirming false racial stereotypes, accessing mental healthcare that is viewed negatively in the cultural community, and beliefs that having a mental illness or accessing mental health care are signs of weakness (Turner *et al*., 2016). Compared with White parents of children with OCD, a study conducted in the UK showed that minoritized parents were more likely to fear stigma and discrimination from within their families and cultural groups (Kolvenbach *et al*., 2018). Shame and denial of mental health symptoms also emerged as salient barriers for patients of colour. In addition, the importance of religion in many communities may discourage clients from disclosing religious obsessions (Beşiroğlu *et al*., 2010; Glazier *et al*., 2015b). As OCD is associated with significant shame and stigma (Glazier *et al*., 2015b), additional cultural and societal stigma can compound a sufferer's fears.

Mental health literacy references the ability to recognize specific disorders, know how to acquire mental health information and treatment, understand risk factors and causes, and adopt attitudes that facilitate recognition of disorders and appropriate help-seeking. Due to reduced representation, education and exposure to mental health care, individuals from minoritized communities may not recognize the development, presentation or treatment options for many mental health conditions (Turner *et al*., 2016; Williams *et al*., 2017c), including OCD which is not often recognized by laypersons (Chong *et al*., 2016), therapists (Glazier *et al*., 2013), physicians (Glazier *et al*., 2015a) and clergy (Jones *et al*., 2019). New immigrants may also be unaware of available resources or fear deportation if their mental health or documentation status is in question (Turner *et al*., 2016). Recognition of a mental health problem as a legitimate concern may also be precluded by symptom somatization, as well as cultural mistrust of mental health professionals (Williams *et al*., 2017c).

Fernández de la Cruz and colleagues (2016) presented ethnoracially diverse parents with hypothetical vignettes in which their child was depicted as having OCD symptoms. White British parents perceived more symptoms, interference and treatment effectiveness associated with OCD than Indian parents. In addition, White parents also perceived greater treatment effectiveness than Black Caribbean parents and more symptoms and interference than Black African parents. Collectively, White participants demonstrated the most knowledge about OCD. These findings highlight a need to consider the mental health literacy of individual clients and to integrate psychoeducation on OCD in outreach, assessment and treatment approaches.

Cultural variations in OCD symptom expression

Culture can significantly impact the expression of OCD symptomatology, and as such, understanding cultural differences in symptom expression is integral to effective assessment and treatment. Current understanding of OCD phenomenology suggests a multi-dimensional structure in which symptoms centre on contamination, responsibility for harm, symmetry, and/or unacceptable thoughts (Abramowitz *et al*., 2010; Williams *et al*., 2013c). Empirical consideration of cultural differences in the expression of these dimensions is emerging. Cultural influences may inform the presentation and under- and over-endorsement of each dimension. Williams *et al*. (2017d) demonstrated that expected gender differences in endorsement of contamination and unacceptable thoughts dimensions were not present in a sample of African American participants. The authors theorized that greater cultural variability in gender roles in African American culture may account for the inability to find greater contamination symptoms in women and greater unacceptable thoughts

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symptoms in men (Orbuch and Eyster, 1997). Furthermore, as considerations of morality are culture-bound, moral and religious concerns embedded in the unacceptable thoughts dimension may differ depending upon an individual's cultural beliefs.

Culture can also influence the rates of endorsement of certain symptoms. Research on OCD in African Americans has shown that African Americans experience contamination symptoms at twice the rate of European Americans (Wheaton *et al.*, 2013; Williams *et al.*, 2012c; Williams and Turkheimer, 2007). One study found that African Americans with OCD were first identified in New York dermatology clinics due to skin irritation from prolonged washing and exposure to cleaning materials. Fifteen per cent of the participants in the sample were diagnosed with OCD, which is significantly higher than would be expected in a non-psychiatric sample (Friedman *et al.*, 1993). Another study conducted at an Egyptian hospital demonstrated that 7.4% of dermatology out-patients presented with OCD symptoms (Motawa *et al.*, 2020). At the same time, most dermatology out-patients with OCD endorsed contamination symptoms. These findings illustrate that POC may be seeking other types of medical care for their concerns.

Some studies also demonstrate elevated contamination concerns in Latinx samples (Williams *et al.*, 2005). Moreover, it has been found in a non-clinical Mexican sample that the most frequent obsessions were related to contamination (Nicolini *et al.*, 1997). Sexual, symmetry, danger and aggressive obsessions were the next most prevalent obsessions in the sample. Furthermore, a study in Rio de Janeiro examined the content of reported obsessions in Brazilians, with the most common theme focused on aggression, contrary to conventional contamination centred on symptom expression (Fontenelle *et al.*, 2007; Matsunaga *et al.*, 2008). Katz and colleagues (2020) did not find greater contamination concerns in any non-White group, but they did find higher rates of magical/superstitious thinking among POC. An over-representation of certain symptom subtypes within ethnoracial groups necessitates a consideration of how stigma and oppression may influence the content of OCD symptoms.

Stigma and oppression embedded in obsessional concerns

Clinicians should understand stigma and oppression in marginalized ethnic groups – including sociocultural hierarchies, minority experience, racialization, White privilege, caste systems, etc. – and how these may be embedded in obsessional concerns. Oppressive and traumatic experiences can influence the nature of individuals' obsessions. For example, African Americans are twice as likely to report animal-related concerns compared with European Americans (Williams and Ching, 2017). This may hold historical cultural relevance because animal attacks (e.g. dogs) were historically used to hunt for slaves and attack civil rights protestors (Williams *et al.*, 2012c).

Previous experiences and negative ethnoracial stereotypes can also affect the phenomenology of OCD for minoritized individuals. Stereotype threat refers to the negative affect and arousal evoked in situations where a group member's behaviour can confirm the negative stereotype about their character in a specific domain (Ben-Zeev *et al.*, 2005; Steele *et al.*, 2002). The endorsement of contamination symptoms in African Americans may be an example of this. Higher rates of obsessions and compulsions related to themes of cleanliness may hold cultural relevance for African Americans, as they have historically experienced segregation due to European American fears of contamination through close contact or sharing objects (Devine, 1989).

When stereotypes and prejudices towards specific groups are salient, affected groups prioritize self-representation strategies to decrease apparent confirmation of the stereotypes and prejudice. Research has found that endorsement of contamination avoidance and aversion by African Americans was greater when stereotype cues were made salient (Olatunji *et al.*, 2014). These findings suggest that amplified views about the importance of cleanliness among African Americans may function to compensate for negative stereotypes about African Americans. Williams *et al.* (2017e) also found that African Americans who report everyday racial discrimination are more likely to experience contamination obsessions, as well as unacceptable

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thoughts obsessions. African Americans may also be hesitant to disclose sexual or aggressive obsessions for fear of validating false racial stereotypes of being sexually deviant or violent (Williams *et al.*, 2017c). Increased efforts at suppressing such thoughts may in turn lead to greater pre-occupation and obsession (Wegner *et al.*, 1987).

There is some evidence to support the idea that minoritized individuals have greater fears of not saying the right thing or being misunderstood (Fernández de la Cruz *et al.*, 2015; Williams *et al.*, 2012c). Such trends may reflect participants' desire to compensate for previous negative racial stereotypes of appearing unintelligent (Fernández de la Cruz *et al.*, 2015; Williams *et al.*, 2012c), and may manifest as compulsive repeating of certain words. It is important to note that clinicians' own stigmatizing attitudes towards minoritized individuals may also lead to diagnoses that confirm pathological stereotypes, including severe mental illness like psychosis, instead of OCD (Chapman *et al.*, 2018). For example, in a case study by Ninan and Shelton (1993), one African American client expressed the delusional belief that blasphemous thoughts were being inserted into his head by Satan. Due to the belief that such thoughts were not generated from his own mind but were rather being inserted into him, he was misdiagnosed with psychosis. Upon closer examination, however, it was revealed that the client also had obsessions with the number seven, as well as compulsions around bathroom rituals and negating his blasphemous thoughts, and so an OCD diagnosis was more appropriate.

The connection between discrimination and OCD

Major and everyday discrimination (e.g. microaggressions) negatively affects physical and mental health and is also linked to higher risk and severity of psychiatric disorders in racialized communities (Berger and Sarnyai, 2015). As previously discussed, discriminatory stereotyping experienced by communities of colour appears to influence OCD symptomatology, as well as the severity of OCD symptoms. Williams and colleagues (2017e) demonstrated that African Americans who reported greater experiences of everyday racial discrimination had a greater number of obsessions and compulsions, and a higher risk of meeting diagnostic criteria for OCD.

Having several marginalized identities can compound the effects of discrimination on OCD phenomenology. Intersectionality refers to belonging to two or more communities that have been historically marginalized (Wadsworth *et al.*, 2020). Race, ethnicity, gender, sexual orientation and ableism constitute some examples of identities that may be societally privileged or marginalized according to group membership. Wadsworth *et al.* (2020) demonstrated that holding more marginalized identities increased OCD symptom severity in the contamination, harm and symmetry dimensions at baseline and discharge for OCD patients. Furthermore, having more marginalized identities was related to increased obsessive beliefs about responsibility/threat over-estimation and perfectionism/certainty at both time points. The authors posited that this relationship could be attributed to marginalization's effect on anxiety symptoms or the inability of assessment tools to measure culturally normative beliefs and values. In addition, the adoption of cleanliness, symmetry, completeness and perfectionism tendencies may be adaptive for overcoming difficulties associated with being marginalized. Experiencing individual and systemic discrimination may also heighten fears around perceived harm and concerns about responsibility and threat.

Encountering discrimination when seeking mental health treatment may be a concern for POC. Seeking treatment may evoke feelings of shame, fear or stigma for having mental health issues at all, and reveal a lack of trust towards the mental health system and therapists (Williams *et al.*, 2017d). Parents also report concerns of systematic discrimination when seeking help for their children of colour (Kolvenbach *et al.*, 2018). In comparison with White British parents, Black African parents were more likely to agree that they would dislike judgement or discrimination of their cultural or ethnic background from a doctor (Fernández de la Cruz *et al.*, 2016). Therapists treating OCD symptoms in POC should discuss how their clients are appraising

and managing experiences of racial discrimination. Additionally, although extremely challenging for clients, clients should be encouraged to persist in their help-seeking efforts, despite the barriers to treatment posed by concerns about discriminatory experiences.

Because the typical client seeking treatment for OCD is White, clinicians may have stereotypes about what sort of problems POC are most likely to have, and that may bias their diagnoses accordingly. Indeed, White individuals with OCD are more likely to receive counselling, Ex/RP or medication in relation to OCD symptoms in comparison with minoritized individuals (Katz *et al.*, 2020). Co-morbidity in OCD is the rule rather than the exception, with high rates of co-occurring depressive, anxiety, traumatic and substance use disorders (Himle *et al.*, 2008). Data examining co-morbidity specifically in racialized communities demonstrates that a staggering majority of African Americans with OCD experience another co-morbid psychological disorder (Himle *et al.*, 2008; Williams *et al.*, 2017a). Mental health professionals commonly misdiagnose OCD (Glazier *et al.*, 2013), and may misdiagnose minoritized clients at a higher rate (e.g. Ninan and Shelton, 1993) due to differing cultural representations of symptoms and their unconscious confirmation of pathological racial stereotypes (Chapman *et al.*, 2018). Clinicians' limited knowledge of OCD symptoms and inadvertent confirmation of their own stigmatizing stereotypes of minoritized clients may thus reduce the focus on OCD symptoms. This can cause clinicians to focus on another problem at the expense of the OCD, which may in fact be driving the co-morbid conditions. For example, one Black research participant we assessed shared that he had requested help for his OCD, but his mental health provider wanted to focus on his depression and other issues instead. The clinician kept putting the OCD on the back burner, saying 'We'll tackle that later', and as a result, the patient never got treatment for the OCD. Furthermore, the intense stigma associated with OCD and African Americans' reported concerns of discrimination and uncertainty of whether to access help for OCD concerns may reduce the likelihood of clients advocating for focusing on OCD concerns in-session (Williams *et al.*, 2012b).

Validated OCD measures may be inadequate for diverse populations

Clinicians should understand that validated OCD measures may be inadequate for minoritized populations. For example, previous findings suggest that African Americans, Latinx Americans and Asian Americans all endorse higher rates of contamination concerns than European Americans (Wheaton *et al.*, 2013). It was also found that perfectionism and difficulty tolerating uncertainty were more predictive of contamination concerns for Asian Americans than for African Americans, Latinx Americans and European Americans (Wheaton *et al.*, 2013). Furthermore, maladaptive perfectionistic symptoms among East Asians specifically may be linked to traditional cultural values (Markus and Kitayama, 1991; Yoon and Lau, 2008), and are further reinforced and reified by the high expectations their parents, teachers and peers may have of them (Schneider and Lee, 1990).

OCD symptoms are varied, and as a result of this tremendous variance, it comes as no surprise that instruments used to measure OCD symptom presentation in non-White samples may not capture the heterogeneity of diverse experiences. Several OCD instruments have not been normed on diverse populations, including both self-report measures and structured interviews. Some instruments shown to be problematic include the Maudsley Obsessional Compulsive Inventory (MOCI; Hodgson and Rachman, 1977), the Padua Inventory (Sanavio, 1988) and the OCD section of the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders-IV Axis I Disorders (SCID-I; Spitzer *et al.*, 1992).

Awareness of this issue emerged in a study conducted by Thomas *et al.* (2000), where it was found that Black undergraduate students consistently produced higher scores on the MOCI in comparison with White participants. This was also demonstrated with the Padua Inventory, where White respondents scored significantly lower on contamination items than Black

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participants (Williams *et al*., 2005). Williams *et al*. (2013b) found that African Americans scored significantly higher on nearly every subscale of the Obsessive-Compulsive Inventory Revised (OCI-R; Foa *et al*., 2002) in comparison with a primarily European American OCD group, demonstrating the need to adjust the measure's cut-off score for African Americans to 36 rather than 21 as proposed in the original validation study. This higher cut-off was used in a study of Black South African women post-partum, and a cut-off of 36 flagged 39% of participants, *versus* 81% with the lower cut-off (Malemela and Mashegoane, 2019), which indicates cross-cultural variability in subjective reporting of symptom severity. In addition, the Dimensional Obsessive-Compulsive Scale (DOCS) has evidenced excellent reliability and promise amongst several ethnoracial groups in the USA, although validation studies are needed with clinical samples (Wheaton *et al*., 2013; Williams *et al*., 2012a; Williams *et al*., 2015b).

In terms of structured interviews, the Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID-I) OCD module is limited for being largely influenced by the administrator's clinical experience, and therefore often produces inconsistent results, especially with African American clients (Chasson *et al*., 2017). For example, it was found that the SCID-I OCD module was more likely to miss less severe clinical levels of OCD in African Americans, particularly when interviewees did not endorse the presence of obsessional thoughts and/or compulsive rituals due to lacking insight and/or awareness. On the other hand, in a study conducted by Williams *et al*. (2013e), the Yale–Brown Obsessive Compulsive Scale (Y-BOCS; Goodman *et al*., 1989a; Goodman *et al*., 1989b) was found to be valid for measuring OCD symptom severity in African Americans. Therefore, a measure's utility in effectively assessing OCD symptoms within diverse populations may relate to its capacity to both account for ethnic and racial differences, as well as accurately capture symptomatic severity even when the client misreports or under-estimates symptoms. The Diagnostic Interview for Anxiety, Mood and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin *et al*., 2018) is a newer interview that has not yet been examined in diverse populations.

CBT treatment approaches may not be as effective for people of colour

CBT and its subset of Ex/RP represent treatments of choice for OCD. However, clinicians should recognize that CBT itself is rooted in European values and that randomized clinical trials of OCD treatment effectiveness have mostly involved White participants (Hays, 2009; Williams *et al*., 2010). The development and assessment of contemporary OCD approaches using mostly White people necessitates an investigation of the treatment's effectiveness on POC. In the UK, Fernández de la Cruz *et al*. (2015) compared White and non-White children and adolescents' OCD phenomenology and treatment response to CBT. Both groups largely demonstrated phenomenological similarities, except for the existence of three marginally significant findings. A trend existed for ethnic minority clients to endorse fears of not saying the right thing and for White clients to endorse engagement in superstitious games and rituals with others. These patterns suggest that CBT treatment targets for non-White youth may differ from those for White youth. Importantly, Fernández de la Cruz *et al*. (2015) demonstrated that White and non-White youth responded equally well to CBT.

Another study conducted by Williams *et al*. (2015a) explored treatment response to CBT in White and non-White children, adolescents and adult clients at a large multi-site specialty treatment facility between 1999 and 2012. As expected, clients were predominantly White but the clinic evidenced a significant growing trend to admit more ethnoracially diverse clients in recent years. In comparison with White participants, minoritized clients had significantly longer treatment durations but did not demonstrate any differences in symptom severity or change scores. The authors hypothesized that differences in treatment duration may relate to cultural differences between clients of colour and the predominantly White clinicians. Promoting clinician and institutional cultural competency can help to ensure that culture is

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integrated and prioritized in treatment. Such integration facilitates effective mental health care that is truly responsive to clients' diverse needs and preferences.

Culturally informed adaptations to CBT can enhance treatment efficacy for minoritized individuals (e.g. Williams *et al.*, 2014). As previously mentioned, a comprehensive and continually developing cultural understanding and assessment of diverse client groups is essential. Williams *et al.* (2014) suggest the use of additional measures that assess ethnic identity (e.g. the Multigroup Ethnic Identity Measure; Phinney, 1992) to provide information about clients' cultural connections that may be employed in the course of treatment. In addition, measures that assess experiences of racism (e.g. the General Ethnic Discrimination Scale; Landrine *et al.*, 2006) can also provide useful information about clients' previous experiences of discrimination, which may affect OCD symptomology and in-session dynamics. Measures like the Brief Religious Coping Scale (Pargament *et al.*, 1998) and Valued Living Questionnaire (Wilson *et al.*, 2010) may also identify client strengths and values that can be used in treatment. Social support networks may be especially important for minoritized clients so clinicians should explore the involvement of important others in treatment (Williams *et al.*, 2014).

Specialized skills

There exist a number of areas where specialized skills may be necessary to successfully treat OCD across race, ethnicity, culture and religion. Skills are a step beyond knowledge as they require effort and training to put into practice. The following sections describe the importance of skills in the areas of outreach practices, cultural respect, flexibility, working with family, differentiation of OCD symptoms from cultural practices, use of culturally specific explanatory models, therapeutic use of the client's worldview and spiritual traditions, and devising acceptable exposures.

Culturally informed outreach practices

Clinicians can adopt several principles and approaches to increase accessibility of services for POC. Clinicians must actively consider their own biases towards minoritized clients to prevent under-serving individuals from these communities (Kugelmass, 2016; Williams *et al.*, 2012b). As cultural mistrust of mental health care is also a barrier to seeking services (Kolvenbach *et al.*, 2018; Williams *et al.*, 2017c), clinicians should endeavour to practise transparency when communicating goals and expectations for treatment (Williams *et al.*, 2012b). Use of the term 'counselling' instead of 'therapy' may reduce concerns and stigma (Thompson *et al.*, 2004). In addition, offering free initial sessions and telephone consultation may help to familiarize clients with services and reduce therapy fears (Williams *et al.*, 2012b). Having ethnically matched and culturally competent staff can also be very helpful for outreach (Turner *et al.*, 2016).

In addition, treatment cost may be a significant concern for POC from low-income communities (Turner *et al.*, 2016; Williams *et al.*, 2012b; Williams and Jahn, 2017). This concern is especially pronounced for those who are not eligible for publicly or privately insured mental health care. Advertising treatment options that range in price (e.g. use of practicum students, stepped care, adoption of a sliding scale) may increase treatment participation and engagement (Williams *et al.*, 2012b). Reduced treatment cost can also support financial losses that are associated with pursuing treatment, like lost wages, childcare and transportation costs (Williams *et al.*, 2012b). Such considerations are especially necessary as there may be fewer OCD treatment options in non-White communities (e.g. Williams and Jahn, 2017).

Awareness of OCD and available treatment options can be improved by maintaining regular contact with community leaders and hosting free community events on mental health (Turner

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et al., 2016; Williams *et al.*, 2012b). Clinicians may also provide referral information to primary care professionals to ensure accessibility of services (Williams *et al.*, 2013d). Referral notices can integrate culturally relevant language and describe symptoms in somatic terms for groups that tend to somatize their mental health experiences (Turner *et al.*, 2016). Treatment should also be advertised as incorporating holistic and alternative approaches that are valued by clients from diverse backgrounds. Acknowledging cultural beliefs and the impact of racial trauma may also increase client comfort and engagement. These strategies can also be employed when promoting services to children, adolescents and families. The need for culturally competent outreach for adolescents, children and families is evident, as a UK-based study illustrated that Black African parents perceived greater barriers to seeking help for potential OCD symptoms experienced by their child than White British, Indian and Black Caribbean parents (Fernández de la Cruz *et al.*, 2016). These parents were the least likely to seek help for a child's OCD symptoms.

Integrating clients' perspectives and preferences into treatment

Consideration and integration of minoritized clients' worldviews and experiences is an essential component of cultural competence (Hays, 2009). Conventional therapeutic approaches' Westernized and present-focused protocols may not always align with diverse clients' lived experiences (Hays, 2009). Individualized conceptualizations of clients' problems may discount social oppression (Sue and Sue, 2016), collectivistic approaches, family hierarchies and spirituality.

Instead of exclusively promoting rapport within session, clinicians can also focus on overt demonstrations of respect for clients, which may be more valued in many cultures (Hays, 2009). As repeated questioning is perceived as disrespectful in several cultures, providing clients with space and autonomy throughout assessments may promote respect for their preferences (Hays, 2006). Carefully integrating self-disclosure (when appropriate) within small talk may also promote respect for clients who value a warm personal approach (Organista, 2006). Respect can also be demonstrated through understanding clients' reluctance to answer certain questions that reflect poorly on the client's culture or family (Paradis *et al.*, 2006). Similarly, collectively integrating culturally related strengths and self-care activities may promote respect and increase treatment engagement (Hays, 2009).

In addition, clinicians can modify their treatment medium or approach to integrate clients' worldviews and experiences. For example, Organista (2006) demonstrated that framing group therapy as an educational experience reduced stigma in Latinx clients. Paradis *et al.* (2006) highlighted that framing OCD treatment as individual therapy may respect Orthodox Jewish clients' treatment preferences and reduce shame. In addition, Black clients may prefer the use of an Afrocentric approach in which positivity, perseverance, faith and family are integrated (Williams *et al.*, 2014). Some minoritized clients may also value a more directive approach, which runs counter to conventional therapeutic norms (Sue and Sue, 2016). Clinicians should also be aware that some minoritized clients may value non-verbal communication or engage in greater concealment as an adaptive measure for protection (Sue and Sue, 2016).

It is also imperative to validate clients' experiences of oppression and refrain from offering alternative hypotheses, even though certain therapeutic approaches encourage exploration of differing explanations, as this can invalidate a client's culture (Hays, 2009). Instead, clinicians can encourage clients to evaluate the helpfulness of certain thoughts or beliefs instead of questioning their validity. Williams *et al.* (2014) also detail how clinicians can provide psychoeducation about how racism may contribute to symptomatology (e.g. Williams *et al.*, 2017e). Clients may further benefit from hearing examples of how treatment has benefited other minoritized clients with OCD (Williams *et al.*, 2014). As clients may be resistant to disclose their symptoms due to cultural mistrust, previous experiences of discrimination and stigma, extra sessions to build rapport may be beneficial.

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As each cultural group is diverse, cultural adaptations to Ex/RP will be significantly different for each client. Clinicians can benefit from exploring previous empirical work and consulting with colleagues on cultural adaptations to existing Ex/RP protocols for specific groups. The investigation by Aslam *et al.* (2015) of a successful brief culturally adapted CBT for OCD in a sample of Pakistani clients elucidates the need for more research evaluating culturally adapted Ex/RP for OCD and provides some useful examples (for a broad overview of cultural adaptations for anxiety and depressive disorders, see Hinton and Patel, 2017). As minoritized individuals may consider therapy as only one means for change, the integration of culturally relevant activities or healing techniques to supplement treatment progress will probably prove beneficial (Williams *et al.*, 2014).

Creating a comfortable environment for treatment

Clinicians should be sensitive to practical aspects when working with minoritized clients to help create a comfortable environment for treatment and reduce potential barriers to care. Clinicians should also be flexible surrounding time, scheduling and location.

It is important to note that concerns over treatment cost may vary internationally, based on availability of services and coverage offered for psychological services (including the UK's coverage of treatment through the NHS). However, if treatment is inaccessible, inconvenient or affects opportunities for employment, clients can be universally affected. First, cultures vary in their orientation towards the concept of time. As such, strict start and end times for some clients may not be appreciated or understood. Integration of a flexible approach to appointment start and end times may increase client comfort and respect.

African Americans cite their occupation, other commitments and transportation as affecting their availability for treatment (Williams *et al.*, 2012b). These concerns are heavily endorsed by individuals who are younger and who have reduced financial resources. Similarly, parents of colour in the UK reported time, money and location inconvenience as barriers to seeking mental health support (Kolvenbach *et al.*, 2018). Clinicians can work to reduce barriers associated with childcare or caring for relatives. Financial constraints and stigma can also be reduced by selecting comfortable community settings with accessible and affordable childcare (Turner *et al.*, 2016; Williams *et al.*, 2013a). Offering appointment times that consider clients' working schedules and other commitments may also abate financial and logistical concerns.

Working with families

OCD affects family relationships, and African Americans with OCD report impairments in their ability to meet their family obligations due to their symptoms (Himle *et al.*, 2008). Family members may also experience frustration and burn-out associated with their loved one's OCD symptoms. A study conducted in Egypt demonstrated that reported family burden between individuals with OCD and individuals with schizophrenia was comparable (Negm *et al.*, 2014). Another study conducted at an Indian hospital illustrated that family members of patients with schizophrenia reported greater overall burden, financial burden and disruption of routine family activities than family members of individuals with OCD (Gururaj *et al.*, 2008). However, no statistically significant differences existed between both populations' disruption of family leisure and family interaction, and effect on physical and mental health of others. Thus, the family burden for OCD is generally similar to that experienced with other severely impairing mental health conditions and is present in several aspects of family functioning. As such, OCD afflicts not just individuals, but their families as well.

In most cultures, family relationships are heavily valued and thus central to the treatment process (Mehta, 1990). Elders are highly respected and honoured by all Asian cultures, and in many cultural groups, parents or grandparents will have the last word on whether treatment

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is permitted. Due to the low participation of POC in OCD research, representative information on the efficacy of family-based treatment is limited (Wetterneck *et al.*, 2012). In India, Mehta (1990) demonstrated that a family-based intervention consisting of directed family member supervision, responsibility and support of recovery resulted in significantly greater improvement of OCD symptoms. The importance of social support from family members for communities of colour suggests that group or family-based therapy may be promising options for OCD treatment (Wetterneck *et al.*, 2012). The existence of extended family structures for such clients also communicates that clinicians' integration and championing of family support in psychotherapy would prove beneficial (Ruggles, 1994; Williams *et al.*, 2017c). To increase treatment participation, clinicians should involve family in consultation and psychoeducation as gaining family support and trust will help the client feel more motivated to stay in treatment and may contribute to an increased prioritization of treatment (Williams *et al.*, 2012b). Families can also be included in the treatment process, through encouragement to complete homework and direct help with exposures if the client is agreeable.

It is also important to note that OCD symptomatology can be affected by various aspects of family life, including family accommodation of OCD behaviours and expressed emotion (consisting of loud communication, criticism, arguments, intrusiveness and demeaning behaviours) (Himle *et al.*, 2017; Vaughn and Leff, 1976). While both dimensions have been associated with poorer treatment outcome or increased symptomatology (De Berardis *et al.*, 2008 Lebowitz *et al.*, 2012), few studies examining family behaviours have incorporated information on ethnicity. With a nationally representative sample of African Americans and Caribbean Blacks, Himle *et al.* (2017) found that individuals with OCD reported significantly higher negative family interactions than those without OCD. Positive family and friend relationships did not attenuate the likelihood of developing OCD. Thus, negative family interactions remain a more potent contributor to OCD symptomatology than positive sources of support. Clinicians must assess the existence of negative family communication patterns and provide family with psychoeducation on OCD and its relationship with negative family interactions to improve treatment outcomes.

Interpersonal difficulties and associated enmeshment from OCD difficulties may be particularly harmful in collectivistic cultures and necessitate additional consideration by clinicians (Williams *et al.*, 2017c). Within collectivistic cultures, creating individual identities that are separated from the family may not be desirable, and so clinicians should aim to communicate treatment as supporting both the family and individual client. Because of the importance and reliance on family support, clinicians should thoroughly assess for family accommodation behaviours that may be misperceived as supporting the client. In addition, client concerns of shaming or dishonouring family members must be considered and respected.

Distinguishing OCD symptoms from cultural and religious practices

Clinicians should both recognize that clients' religions do not cause OCD and accept clients' legitimate religious practices. A client's religious values should be respected and integrated into treatment when possible, as often the OCD gets in the way of carrying out proper religious duties (i.e. prayer, attendance at services, normal rituals) rather than improving religious life (Himle *et al.*, 2012; Huppert *et al.*, 2007). The clinician should demonstrate that adherence to excessive, OCD-driven religious behaviour is debilitating and impairing over time (Huppert *et al.*, 2007), and differentiate it from normative cultural and religious practices. For example, in one study examining religious OCD symptoms among young Muslim women from Saudi Arabia, it was found that the most prevalent symptoms were centred around the five daily prayers and their preceding ablution rituals (Al-Solaim and Loewenthal, 2011). All interviewees in the study found their OCD symptoms related to religious life as most distressing, interfering, time-consuming and physically exhausting when

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compared with obsessional behaviour in other domains of life such as schoolwork. In addition to being distressing, interviewees reported that their religious OCD also resulted in significant impairment, with one participant stating that she repeated prayers so many times she had to miss school on several occasions and another acknowledging that she began taking too long to complete ablution practices.

Scrupulosity OCD exists in religious communities across all traditions, although recent findings indicate that scrupulous presentations may vary between religious affiliations (Buchholz *et al.*, 2019). For example, among Jewish and Christian groups, Christians engage in greater moral thought–action fusion, an element of OCD (Siev *et al.*, 2010). They argued that moral thought–action fusion was culturally normative for Christians and only predicted OCD symptoms in Jewish populations. This finding is consistent with original research that demonstrates that non-Christian groups report reduced scrupulous symptoms (Abramowitz *et al.*, 2002), which could be attributed to the influence of Christianity on current scrupulosity measures (Summers and Sinnott-Armstrong, 2019).

Understanding culturally predicated explanatory models for OCD symptoms

Individuals from minoritized communities may use culture-specific models to inform their understanding of their symptoms, and as such, clinicians must be able to understand the client's culturally predicated explanatory model for OCD symptoms. In the UK, Fernández de la Cruz *et al.* (2016) demonstrated that participants' perceived causes for their child's hypothetical OCD symptoms differed based on ethnoracial identity. For example, White British and Black Caribbean parents most commonly attributed personality, emotional problems, trauma and family/parenting problems as causing OCD symptoms. However, Indian parents also believed in the influence of their child's friends instead of a potential trauma and Black African parents also selected physical causes instead of family or parenting problems. Black African parents were also less likely to endorse biopsychosocial causes for OCD symptoms than White British parents. Non-White individuals were also more likely to report that they would seek help for OCD symptoms from a religious leader.

An international survey study found notable East–West differences in explanatory models for OCD (Yang *et al.*, 2018). Compared with respondents in the USA and Western Europe, people in East Asia had more negative views about someone with OCD. East Asian participants were more likely to blame the person, consider the symptoms to be part of the person's personality, and recommend the sufferer to not seek help from others. Those from East Asian countries were also more likely to recommend alternative therapies like acupuncture and herbal medicines. Those from Western countries had a more favourable view of causes and psychosocial interventions for treating the disorder.

In another study, approximately one-third of OCD out-patients from an Indian hospital reported seeking support from faith healers or exorcists and almost half associated their OCD symptoms with supernatural causes, including sorcery, ghosts, spirit intrusion, divine wrath, planetary influences, evil spirits and wrongdoings in a past life (Grover *et al.*, 2014). Moreover, 34% of clients attributed their symptoms to more than one supernatural cause. Clients who initially consulted faith healers and traditional healers for their symptoms were more likely to have beliefs in spirit intrusion, sorcery and/or witchcraft. These clients were also more likely to attribute their symptoms to various supernatural causes. In addition, clients who attributed their mental illness to past bad deeds in a previous life had significantly longer durations of illness. Thus, clinicians must consider the prevalence of culturally predicated models and their effects on the treatment process and outcomes.

For clients with strong religious affiliations, religious OCD symptoms may be internally and externally stigmatized and attributed to previous inadequate developmental experiences and excessive religiosity instead of medical and psychological explanations (Pirutinsky *et al.*, 2009). Such attributions may amplify shame and ostracization in such individuals. As the study of

Grover *et al.* (2014) highlighted that about half of out-patients reported magico-religious beliefs within their community, it is imperative that clinicians understand the influence of cultural beliefs held by both clients and community members to ensure accessible and representative care. Indeed, parents of colour cite differing cultural beliefs about mental illness as a barrier to seeking treatment for their children (Kolvenbach *et al.*, 2018). Awareness and integration of cultural models within psychological models is thus a necessary component of clinical cultural competence.

For some ethnic groups such as African Americans, framing OCD as an inherited, biological disorder rather than a 'mental illness' is more acceptable and less stigmatizing. African Americans are socialized to be mentally strong, and may fear that OCD is a sign of mental weakness, whereas having a treatable medical condition may be seen as more acceptable. On the other hand, among East Asian groups, mental disorders are highly stigmatized due in part to their potential to be inherited, which can make it hard to find marriage partners for people from families where anyone has a serious mental disorder (Lauber and Rössler, 2007). As a result, it is advisable for clinicians to frame OCD as learned habits that can be resolved through education and training.

Making treatment compatible with the client's worldview

Conceptualizations of psychological well-being may vary cross-culturally (Yip, 2005). That being said, while OCD symptoms may be group or culture specific (Williams *et al.*, 2017b), they are always distressing or impairing. Thus, clinicians must be able to translate clinical information into a framework that is compatible with the client's worldview for understanding and treating OCD, while simultaneously being able to demonstrate that OCD symptoms are psychopathological, and not due to individual or group differences. As a result, normative behaviour in the community with which the client identifies can and should be used as a reference point to distinguish between acceptable risk and OCD behaviour (Huppert *et al.*, 2007). For example, it may be appropriate for clinicians to ask questions such as, 'Do your friends also engage in this behaviour as intensely or frequently as you do?' (Huppert *et al.*, 2007).

Similarly, it may also be useful for clinicians to consult community members in order to learn what is considered normative within a client's specific group/tradition (Huppert *et al.*, 2007), as well as to learn how to best translate and convey clinical information to clients in a manner that corresponds to their worldview. Avoiding religious content in the therapeutic conversation is unnecessary and often counterproductive (Leins and Williams, 2018). Within the Christian community, there has existed antagonism between one camp of therapists espousing Biblical counselling and the other championing a more 'secular' form of psychotherapy, which has led to even stronger opinions about whether it is advisable to highlight religious principles in the therapeutic context (Leins and Williams, 2018).

While religion is not an aetiological factor in scrupulosity OCD (Huppert *et al.*, 2007), notable differences in symptomatic presentation across cultural and religious groups do exist, possibly due to different conceptualizations of God or the Divine (Leins and Williams, 2018), or cosmology more generally. For example, some religions such as the Abrahamic traditions, which characterize God as sometimes punitive, may lay the groundwork for instilling an obsessional fear of sinning or being condemned by God (Williams *et al.*, 2017b). Meanwhile, other non-theistic religions such as Buddhism may give rise to different fears such as the fear of attaining a bad rebirth (Lam *et al.*, 2010). Other fears may include fears that are not attached to a specific religion, but rather attend to more supernatural concerns such as spirit possession, demonic possession, or receiving a hex such as the evil eye (Spiro, 2005). Clinicians must acknowledge these origins, effectively differentiate between cultural group differences and psychopathology, and integrate beliefs and values when translating clinical information to the client during treatment.

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Working with traditional healing and healers

Help-seeking behaviours may be culture specific and vary from group to group, with some clients preferring the integration of spiritual, traditional and folk healers in their treatment. For example, among Muslim populations, seeking out advice on how to deal with OCD symptoms from Imams prior to mental health professionals is not uncommon (Al-Solaim and Loewenthal, 2011). Clinicians should appreciate these modalities and collaborate with them as necessary. Consulting a variety of experts on religion including clergy members, traditional healers and religious scholars can prove useful in facilitating religious psychoeducation (Arip *et al.*, 2018), as well as in determining the boundaries of exposures for clients with OCD (Huppert *et al.*, 2007). One example of religious leaders' support is Islamic jurists' alleviation of OCD symptoms through demonstrating that the Qur'an does not support ideas of thought–action fusion or thoughts as consequential (Keshavarzi *et al.*, 2018).

Clinicians can support their clients' spiritual beliefs through doing more than just acknowledging them. Clinicians must also be willing to integrate religious and cultural values into the therapeutic process. For scrupulous Christians, this means working with the Bible in order to facilitate a more personal approach to treatment, as well as to validate any commitments to biblically oriented therapeutic goals the client might have (Leins and Williams, 2018). In the Islamic context, this translates to working with the Qur'an and the Hadith (Arip *et al.*, 2018; Keshavarzi *et al.*, 2018). Integrating a discussion around clients' spiritual beliefs into the therapy process for individuals with OCD has been shown to be extremely effective. For example, treating Christians with scrupulous themes of OCD with Ex/RP that centralizes the compatibility of the intervention's tenets with Biblical scripture may be more effective than Ex/RP detached from culturally or religiously sensitive narratives (Leins and Williams, 2018).

Collaboration with traditional and religious healers could encompass consulting healers through national forums, establishing working alliances as joint mental health professionals, consulting confidentially on the client's case with the client's consent, and inviting healers to deliver training to clinicians to enhance cultural competence (Pouchly, 2012). Drawing from interviews conducted with traditional healers in Uganda, Ovuga *et al.* (1999) outlined two potential organizational systems for collaboration between traditional healers and clinicians: (1) a sequential approach, in which clinicians and traditional healers could make referrals to each other and (2) a simultaneous approach, in which healers and clinicians could operate within the same service and receive joint training. The sequential approach may work best within the context of the UK's NHS and potential resource restrictions, but the simultaneous approach warrants further consideration and study (Pouchly, 2012).

It is also important to note that both clients who are and are not religiously scrupulous may endorse traditional approaches to healing, such as yoga, Ayurveda, astrology, Voodoo, Santeria, Qi-gong and Sahaja, (Moodley and Sutherland, 2010), as well as traditional Chinese medicine (Liu, 1981), meditation (Neki, 1973), and/or shamanism (Metzner, 1998). Clients may also identify with traditions that have a long history of sacralizing entheogenic plants such as the Santo Daime tradition of Brazil (Blainey, 2015). Examining spiritual beliefs and practices in psychotherapy may provide the clinician with a greater understanding of clients as represented through cultural metaphors, symbols and archetypes (Moodley and Sutherland, 2010).

Devising exposures that do not violate religious or core cultural beliefs

Developing cultural sensitivity is particularly important when devising effective exposures that do not violate a client's religious tradition or core cultural beliefs. This is especially salient for certain ethnoracial groups who report religious concerns as barriers to OCD treatment (Fernández de la Cruz *et al.*, 2016). In order to conceptualize what is and is not culturally permissible during Ex/RP,

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it may be useful for clinicians to consult a relevant clergy member or religious leader (Huppert *et al.*, 2007). This is recommended because exposures do not usually require individuals to bring about negative consequences directly, but are rather designed to habituate the individual to ultimately allow for tolerating risk, ambiguity and uncertainty surrounding an event. They also note that while *in vivo* exposures can be effective, it is neither necessary nor appropriate to ask the client to commit an actual sin (see also Williams and Wetterneck, 2019).

Imaginal exposures do not usually result in the client committing sin, and may also expose the client to therapeutic scenarios that cannot be experienced *in vivo* such as going to Hell. Other forms of culturally sensitive exposure techniques include integrated exposure and prevention therapy, which seeks to incorporate a variety of religious elements in the form of religious psychoeducation (Arip *et al.*, 2018). This psychoeducation consists of teaching healthy techniques to glorify God, listening to clergy members and scholars speak about scrupulous behaviour, and regularly reviewing homework and assignments on scripture and holy texts (Arip *et al.*, 2018). Similarly, Aouchekian *et al.* (2017) showed that religious CBT is an effective approach for treating religious OCD in a group of Muslim women. Sessions integrated the clients' religious beliefs while directly targeting distorted cognitive beliefs which helped to significantly reduce OCD symptoms, with gains persisting after 6 months.

Discussion

Summary

The current work highlights the importance of reflection, respect, consultation and integration of different worldviews, models of mental illness, symptom expressions, experiences of oppression, and values in the assessment and treatment of OCD. Clinicians must acknowledge and counteract personal biases through introspection and consultation if they are to become culturally competent. It is also integral that clinicians recognize many clients' experiences of compounded stigma from both having OCD and being part of a racialized community that experiences oppression and mistrust of the mental health system, as oppression, stereotype threat and stereotype compensation have the potential to contribute to obsessional content and associated compulsions.

Standardized OCD assessment measures do not examine these factors adequately and are often not validated on diverse populations. As such, they may be inadequate for assessing diverse populations and may have the propensity to either over- or under-diagnose OCD symptoms (Chasson *et al.*, 2017; Thomas *et al.*, 2000; Williams *et al.*, 2005; Williams and Turkheimer, 2007). Clinicians should therefore use culturally validated measures like the OCI-R and YBOCS, and when this is not possible, should consider the accuracy of test results and communicate such findings with caution.

As discussed throughout, diverse clients may utilize many different avenues to find help for their OCD. Common examples of alternate help-seeking behaviours among various cultural groups can be summarized as follows (Turner *et al.*, 2016; Williams *et al.*, 2017b):

- Alternative healing methods (e.g. herbal medicine, acupuncture)
- Family and community advice and support
- Religious and spiritual sources of support
- Traditional or folk healers, clergy
- Engagement through primary care
- Use of emergency room services

Of course, we should not forget that many racialized people do seek help from professional therapists and counsellors (e.g. Katz et al., 2020), and may still not find help for their OCD

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due to a shortage of mental health professions trained to treat OCD, which is likely to be even more so in communities of colour.

One way treatment providers can increase client comfort and engagement is through community consultations, accessible psychoeducation, transparent dialogue, and involvement of diverse and culturally competent staff. In recruitment notices and exchanges with diverse communities, mistrust and fear surrounding engagement in research and treatment should be acknowledged. Offering treatment at flexible times, situating treatment at accessible locations, and creating welcoming spaces for family and close others in-session and in treatment waiting rooms can also offset many barriers. The importance of family to a client should be respected and may be demonstrated through involving family in consultation and psychoeducation about OCD, as well as providing information about the harms of family accommodation. Family can also be an integral component of treatment when desired.

Clinicians should be open to adapting conventional therapeutic approaches and integrating treatment approaches, which are cognizant of the client's values. Differentiating experiences of OCD from normative cultural and religious experiences may involve consultation with community leaders and religious/spiritual healers, education on cultural experiences, peer consultation with multicultural clinicians, and consideration of the distressing and impairing nature of the behaviour. Such collaboration ensures that exposures do not violate religious, spiritual or cultural norms. We also advise clinicians to respect and integrate clients' models of attribution for their OCD symptoms and the importance of collaborative support with religious and traditional healers.

Limitations

Some findings presented in the work above are based on the larger mental health literature as there is a dearth of research specifically examining the relationship of OCD and culture. We also acknowledge that relevant research conducted in other cultures that is not available in English is not represented here. In addition, much of the discussed research and literature was conducted in North America and Europe. Thus, researchers' understanding of OCD symptoms and treatment may be influenced by contemporary Western conceptualizations of mental illness.

The findings may also not be applicable to individuals with OCD from other countries. As it may be difficult to assess all cultural groups in individual studies, some of the findings may be limited to individuals of only one specific community. Lastly, the cross-sectional nature of much of the discussed research limits the potential to make causal claims about diverse individuals' experiences of OCD. It is important to note that individuals within cultural groups experience idiosyncratic differences that may be distinct from their culture. Clinicians should recognize that these findings and recommendations will not apply for every member of a particular group. Clinicians should thus incorporate discretion and consultation, as well as collaboration with clients to create conceptualizations and treatment approaches that reflect the client's individual preferences and experiences.

Future directions and research

Despite considerable progress over the last decade to better conceptualize OCD and OCD treatment more broadly, more research is needed to understand symptom differences, cultural attitudes and treatment approaches in non-White and non-Western populations. While research has begun to explore common cultural variations of OCD in diverse populations, we argue that researchers should expand these investigations and replicate previous results. Expanding beyond religious OCD symptoms to explore how other aspects of culture influence obsessional content is also of empirical and clinical interest. The impacts of acculturation and

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generational status on OCD phenomenology, help-seeking behaviours and treatment response is also considerably unexplored. In addition, researchers could further investigate how experiences of microaggressions, oppression and racial trauma contribute to OCD symptoms and treatment. Exploration of cultural manifestations of OCD within children and adolescents is also lacking (e.g. Williams and Jahn, 2017).

Specific attention to the effectiveness of OCD treatment for POC is necessary to ensure that existing protocols are reflective and representative of the entire population. Empirical investigation of cultural adaptations to traditional Ex/RP protocols would prove beneficial in understanding OCD and its treatment. Other sources of investigation could include the formal integration of community leaders, healers and clergy, as well as complementary and alternative medicine into treatment. Research could also investigate which culturally responsive outreach practices are most effective within different ethnoracial communities. Finally, prioritizing the selection of nationally representative samples (like that derived from the National Survey of American Life or the National Latino and Asian American Study; Jackson *et al*., 2004; Takeuchi *et al*., 2012) may also ensure generalizability of research on OCD phenomenology and treatment.

Conclusion

There is ample evidence from both the larger mental health literature and the OCD literature specifically that the competencies described herein are important for conceptualizing cultural issues and treatment outcomes within communities of colour. We argue that clinicians should consider and accordingly counteract any personal, organizational and therapeutic biases and norms that do not integrate clients' diverse experiences. Furthermore, collaboration with other professionals such as community and religious leaders, is necessary to produce culturally competent assessments and treatment approaches that respect clients' worldviews and values. Therefore, clinicians should be willing to adapt treatment, accommodate barriers and engage in open, transparent dialogue with themselves, colleagues, community members and clients to support the diversity of those in their care.

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Key practice points

(1) Diagnosing and treating OCD can be complicated due to the wide variety of symptom presentations associated with the disorder.
(2) Adding differences due to race, ethnicity, culture and religion can make working with this challenging disorder even more complex.
(3) Therapists should understand that symptoms may present differently in various ethnoracial groups, due to differences in ethnicity, culture, religion or race.
(4) CBT approaches may need to be adapted to account for different worldviews, religious beliefs and family considerations.
(5) Therapists should consult with others as needed, including traditional healers, members of the client's community, and culturally competent mental health experts for guidance.

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