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Original article

Mental health stigma in Latin American youth with obsessive-compulsive disorder

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A R T I C L E I N F O

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A B S T R A C T

Obsessive-compulsive disorder (OCD) is an impairing mental health condition that affects individuals across the lifespan. Some literature has evaluated mental health stigma in adults with OCD but limited attention has been given to youth, as well as those of Latino ancestry. The present study reported the extent of stigma experiences among Latin American youth with OCD, as well as examined sociodemographic, clinical and psychological correlates. 235 youth with clinician confirmed diagnoses of OCD from 10 North and South American countries completed questionnaires assessing stigma experiences, symptomatology, and functioning. Sociodemographic and clinical variables were also collected. The average OCD stigma response corresponded to a frequency rating of "rarely" (M=16.4 on an 8 to 40 possible range), though 42.1% of the sample endorsed experiencing at least one stigma-related item "often" or greater. Multivariate regression analyses indicated that depressive symptomatology was the strongest predictor of stigma, with no sociodemographic or clinical variables independently associated with stigma. Additional regression analyses revealed that stigma was uniquely associated with higher clinician-rated OCD symptom severity and higher parent-rated impact of OCD, but stigma did not independently associate with youth-rated quality of life. Findings highlight that stigma related concerns affect many Latin American youth with OCD, with links to worse psychological health.

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1. Introduction

Obsessive compulsive disorder (OCD) is a disabling psychiatric condition with an estimated lifetime prevalence of 1.3% (Fawcett et al., 2020). Obsessive-compulsive symptoms onset during childhood in approximately 50–70% of affected individuals (Anholt et al., 2014). Among children and adolescents (referred to as "youth" herein), OCD is associated with significant impairments in quality of life (Coluccia et al., 2017; Storch et al., 2018), considerable economic burden on society (Lenhard et al., 2023; Strouphouer et al., 2023), and commonly continues into adulthood if not adequately treated (Micali et al., 2010).

Mental health stigma is a well-documented barrier to treatment and recovery in OCD. Stigma encompasses stereotypes, prejudice, and discrimination toward individuals with mental health conditions and may be experienced both externally and internally (Fox et al., 2018). Among individuals with OCD, greater stigma has been associated with reduced treatment seeking and poorer clinical outcomes, including more severe obsessive-compulsive symptoms, higher comorbid anxiety and depression, and lower quality of life (Belloch et al., 2009; Glazier et al., 2015; Kaur et al., 2023; Kılıç et al., 2022; Lorona et al., 2018; Marques et al., 2010; Ociskova et al., 2021; Picco et al., 2017; Williams et al., 2012). However, this literature has been conducted almost exclusively in adults, limiting understanding of stigma experiences and correlates during development. Experiences of stigma are shaped by developmental and environmental contexts (DeLuca, 2020; Heary et al., 2017), and youth – who have less power and agency and are actively developing autonomy and social identity – may be particularly vulnerable to its harmful effects. Although research has documented the negative impact of mental health stigma in youth broadly (Kaushik et al., 2016), OCD may present unique stigma-related challenges due to variability in public stigma across symptom presentations and frequent misrecognition of the disorder (McCarty et al., 2017; Trompeter et al., 2022). To date, evidence specific to youth with OCD has been limited to a small number of qualitative studies, which link stigma to shame, fear of being perceived as "crazy," secrecy surrounding symptoms or diagnosis, and barriers to disclosure and recovery across cultural contexts (Keyes et al., 2018; Khesht-Masjedi et al., 2017; Sravanti et al., 2024; Vallani et al., 2023). Notably, no study has quantitatively examined the correlates of stigma in a larger, diagnosed sample of youth with OCD.

Further, experiences of stigma among individuals of Latin American decent with OCD - a population largely overlooked within the OCD literature (Morris et al., 2024; Wetterneck et al., 2012) - have yet to be directly examined. This gap is particularly concerning given that Latin Americans reported greater public and self-stigma toward mental health concerns compared to White individuals of European ancestry (Mascayano et al., 2016; Misra et al., 2021; Turner et al., 2016). Elevated stigma within this population may reflect cultural factors such as concerns about the impact of mental illness and treatment on the family (i.e., *familismo*), labeling mental illness as being "crazy," fears of appearing weak rooted in *machismo*, intersections between mental health and immigration status, and tensions among psychological, medical, and spiritual explanatory models of symptoms (Misra et al., 2021; Turner et al., 2016). Consistent with these barriers, Latino youth in the United States are the least likely of any ethnic group to receive mental health care, potentially reflecting stigma-related obstacles to help-seeking (Turner et al., 2016). Within the context of OCD, limited evidence further suggests that Latin American youth may misunderstand and stigmatize hypothetical depictions of OCD, underscoring the broader relevance of stigma within this population (Trompeter et al., 2022).

Given these gaps, this study sought to evaluate OCD stigma among Latin American youth. The aims of this investigation were multifold. First, we sought to describe the extent of mental health stigmatization among this population. Second, we aimed to determine the sociodemographic and clinical factors that predicted greater stigma. Third, we aimed to evaluate whether OCD stigma is uniquely associated with worse psychological outcomes.

2. Methods

2.1. Procedure

Data collection occurred through the Latin American Trans-ancestry Initiative for OCD genomics (LATINO; Crowley et al., 2024). LATINO is large scale research initiative and network across the United States and Latin America designed to enhance the genomic understanding of OCD. Recruitment occurred across a series of clinics, universities, psychiatric hospitals, day treatment programs, and/or partial hospitalization programs with foci in the treatment of OCD. Individuals were recruited in-person at participating sites or via country-specific online methods (e.g., social media). To be eligible to participate in LATINO, individuals are required to meet criteria for an OCD diagnosis (current or past) by structured diagnostic interview or score above a 15 on the Yale-Brown Obsessive-Compulsive Scale, Second Edition (Y-BOCS-II; Storch et al., 2010) or Children's Yale-Brown Obsessive-Compulsive Scale, Second edition (CY-BOCS II; Storch et al., 2019), be between 7 and 89 years old, and have at least one biological grandparent of Latin American heritage. As part of their participation, individuals provided a saliva DNA sample and underwent a clinical battery consisting of clinician-administered and self-/parent-report measures, as well as provided demographic and treatment history information. These assessments occurred either in-person or via virtual platform. All sites followed consistent inclusion and diagnostic procedures as guided by a centralized study protocol. All assessments used were available for use in English, Spanish, or Portuguese. Study data were collected and managed using REDCap (Research Electronic Data Capture) hosted at Baylor College of Medicine (Harris et al., 2009; Harris et al; 2019). Further information regarding the LATINO project are detailed in Crowley et al. (2024).

The present study is a secondary data analysis of a selection of measures within the LATINO study battery for individuals who a) were between the ages of 7 and 17 years inclusive, b) provided at least partial data for each of the measures of interest, and c) met current criteria for OCD per clinician assessment.

2.2. Measures

2.2.1. Clinician administered

Diagnosis of OCD and presence of psychiatric comorbidities were confirmed using the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID; Sheehan et al., 2010) and select modules of the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2018). Symptom severity of OCD was assessed by the 10-item severity score of CY-BOCS-II (Storch et al., 2019), with total scores ranging from 0 to 50 ($\alpha = 0.90$). Clinician administered measures were completed by trained raters (described further in Crowley et al., 2024).

2.2.2. Youth-reported stigma

Experiences of stigma related to OCD were assessed by the 8-item Patient-Reported Outcomes Measurement Information System Stigma measure (PROMIS; Molina et al., 2013), which assesses both enacted and internalized experiences of stigma. Items are rated on a 1 (never) to 5 (always) point Likert scale, with total scores ranging from 8 to 40. A full list of the items administered to the participants is provided in Table 2. In the present study, internal consistency was excellent ($\alpha = 0.93$). Further, a post hoc assessment of this measure's internal validity via a principal component analysis revealed a single factor accounting for 66.8% of total variance.

2.2.3. Youth-reported symptomatology

Depressive and anxiety symptomatology were assessed using the 8-item PROMIS Depression and Anxiety Scales for youth (Quinn et al.,

2014). Items are rated on a 1 (never) to 5 (almost always) point Likert scale, with total scores for each scale ranging from 8 to 40. Internal consistency was excellent for both the depression (α = 0.95) and anxiety (α = 0.92) scales.

2.2.4. Youth-reported quality of life

The 14-item Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire (PQ-LES-Q; Endicott et al., 2006) assessed quality of life and satisfaction across the domains of physical health, mental health, and well-being. Items are rated on a 1 (very poor) to 5 (very good) point Likert scale, with total scores ranging from 14 to 70. Internal consistency was excellent (α = 0.90).

2.2.5. Parent reported impact of OCD

Parents of the participating youth reported on the impact of their child's OCD on several domains of life using a 1 (very little or no impact) to 5 (very significant impact) point Likert scale. For this investigation, four domains were selected for examination: social life, engagement and attainment in education, family in general, and overall well-being and quality of life. These items were averaged to create a composite score of parent-rated impact of OCD, with scores ranging from 4 to 20 (α = 0.84). To estimate the internal validity of this sum score, a principal component analysis was conducted which revealed a single factor accounting for 67.5% of variance.

2.2.6. Sociodemographic and clinical variables

The following data was collected through interview, medical record review, and demographic questionnaires completed by parents: participant age, biological sex, racial and ethnic identification, country of recruitment, family income relative to country average (rated on a 1 to 5 point Likert Scale), prior history of psychotropic medication, and prior history of any form of psychotherapy for OCD.

2.3. Participants

Our sample consisted of 235 youth (50.7% male, $M_{age} = 13.9$) with a diagnosis of OCD. Of those that provided information regarding ethnicity, most self-identified as Hispanic or Latino (88.9%).[1] Participants were recruited from 21 different recruitment sites across ten different countries, most frequently Mexico (30.6%), Brazil (19.1%) and the United States (18.7%). Most of the sample (84.7%) demonstrated evidence of at least one psychiatric comorbidity. Common psychiatric comorbidities included Generalized Anxiety Disorder (37.0%), Attention-Deficit/Hyperactivity Disorder (31.5%), Separation Anxiety Disorder (28.9%), Social Anxiety Disorder (20.4%), and Major Depressive Disorder (16.6%). Most participants reported receiving previous therapy for (78.3%) or psychotropic medication (69.8%). Table 1 further illustrates participant characteristics.

2.4. Analytic plan

Data analyses were conducted in IBM SPSS Version 31. Overall, 1.4% of data points were missing, with 42.3% of cases missing at least one value. Missing data were addressed using multiple imputation with fully conditional specification, including all study variables as both predictors

[1] The authors acknowledge that Latino ancestry is diverse and reflects the integration of Indigenous, African, and European ancestry due to Spanish and Portuguese colonization in the Americas. As such, the term "Latino" may not be recognized by those from Spanish and Portuguese-speaking countries in Latin America; some may prefer other terms such as "Latinx, Latine, Hispanic, Chicano/a, or Tejano/a." To remain consistent with previous literature, the authors will use "Latino" to refer to an individual of Latin descent for the purposes of this work (Gearing et al., 2024; Lopez et al., 2020; National Museum of the American Latino, 2024).

Table 1
Sample characteristics ($N = 235$).

Characteristic	*n*	%	*M* (*SD*)	Range
Youth Age			13.9 (2.8)	7 - 17
Youth Sex				
Female	116	49.4		
Male	119	50.6		
Youth Racial Identification				
American Indian/Alaskan Native	5	2.1		
African American or Black	3	1.3		
Asian	1	0.4		
More than one Race	38	16.2		
Other/Unknown	76	32.3		
Pardo	9	3.8		
White	103	43.8		
Youth Ethnic Identification				
Hispanic or Latino	168	71.5		
Not Hispanic or Latino	21	8.9		
Ethnicity Not Assessed	46	19.6		
Language of Assessment				
English	41	17.4		
Portuguese	45	19.1		
Spanish	149	63.5		
Country of Recruitment				
Argentina	21	8.9		
Bolivia	16	6.8		
Brazil	45	19.1		
Chile	13	5.5		
Colombia	13	5.5		
Ecuador	1	0.4		
Mexico	72	30.6		
Paraguay	2	0.9		
Peru	8	3.4		
United States	44	18.7		
Parental Monthly Income (Relative to Country Average)				
Much less	22	9.4		
Somewhat less	34	14.5		
About the same	60	25.5		
Somewhat more	49	20.9		
Much more	16	6.8		
Unknown	54	23.0		
Treatment History				
Ever take any psychotropic medication[a]	164	69.8		
Ever receive any form of psychotherapy for OCD[b]	184	78.3		
Categories of Comorbid Diagnoses				
Any Anxiety Disorder	153	65.1		
Any Bipolar and Related Disorder	9	3.8		
Any Depressive Disorder	39	16.6		
Any Feeding and Eating Disorder	24	10.2		
Any Neurodevelopmental Disorder	93	39.6		
Any Obsessive-Compulsive and Related Disorder (other than OCD)	59	25.1		
Any Schizophrenia and Psychotic Spectrum Disorder	12	5.1		
Any Substance-Related and Addictive Disorder	4	1.7		
Any Trauma- and Stressor-Related Disorder	20	8.5		
Total Number of Comorbid Diagnoses			2.6 (2.3)	0 - 10
Symptomatology & Functioning				
CY-BOCS-II Total Severity[c]			22.5 (8.1)	1 - 46
PROMIS Anxiety[d]			22.1 (8.3)	8 - 40
PROMIS Depression[e]			20.7 (8.7)	8 - 40
PQ-LES-Q[f]			49.2 (9.6)	26 - 69
OCD Impact (parent rated)[g]			12.4 (4.0)	4 - 20

Note: Non-imputed data is presented. CY-BOCS-II = Children's Yale-Brown Obsessive-Compulsive Scale, Second edition; PQ-LES-Q = Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire.
[a] Responses unknown for 8 participants.
[b] Responses unknown for 11 participants.

[c] Responses unknown for 1 participant.
[d] Responses unknown for 5 participants.
[e] Responses unknown for 6 participants.
[f] Responses unknown for 8 participants.
[g] Responses unknown for 35 participants.

and targets for imputation. Twenty-five imputed datasets were generated and pooled using Rubin's rules (Rubin, 1987), with ranges reported where pooling was not applicable. Within-subject 95% confidence intervals for non-imputed PROMIS stigma item means were calculated using the Cousineau-Morey method (Baguley, 2012). Univariate associations between stigma and sociodemographic, clinical, symptom, and functioning variables were examined using Pearson correlations, independent samples *t*-tests, and ANOVAs. Cohen's d was calculated for pairwise effect sizes (Cohen, 1988).

To examine unique predictors and outcomes of stigma, a series of ordinary least squares linear regressions were conducted. The first model predicted total stigma from age, sex (1 = male, 0 = female), racial identification (1 = White, 0 = not White), ethnicity (1 = Hispanic/Latino, 0 = not Hispanic/Latino), subjective income, country (1 = USA, 0 = not USA), number of comorbid diagnoses, prior OCD psychotherapy (1 = yes, 0 = no), prior psychotropic medication use (1 = yes, 0 = no), and OCD, depression, and anxiety severity. Three additional hierarchical regressions predicted OCD severity, youth-rated quality of life, and parent-rated OCD impact. Step 1 included all covariates (excluding OCD severity in its own model), and Step 2 added stigma. All predictors and outcomes were standardized within each imputed dataset prior to analysis, yielding standardized β coefficients, with effect sizes interpreted as 0.1 (small), 0.3 (medium), and 0.5 (large) (Cohen, 1988).

3. Results

3.1. Extent of stigma

On average, participants scored 16.41 (*SD* = 7.78; range 8–40) on the PROMIS stigma measure, corresponding to an average frequency response of *rarely* across all items (i.e., a score of 2). Table 2 presents the non-imputed descriptive statistics for the individual items of this measure. 66.4% of the sample endorsed at least one stigma item at *sometimes* or greater frequency (i.e., score of 3 or higher), and 42.1% endorsed at least one stigma item at *often* or greater frequency (i.e., score of 4 or higher). Items 2, 4, and 7, each assessing internalizing forms of stigma, demonstrated the highest mean endorsement. Fig. 1 provides an additional visualization of stigma item means.

3.2. Univariate associations with stigma

In univariate analyses, stigma was positively associated with age (r_{pooled} = 0.18, p = .007), OCD severity (r_{pooled} = 0.28, p < .001), depression symptoms (r_{pooled} = 0.55, p < .001), anxiety symptoms (r_{pooled} = 0.33, p < .001), total number of comorbid diagnoses (r_{pooled} = 0.23, p < .001), and parent-rated impact of OCD (r_{pooled} = 0.48, p < .001). Stigma was found to be negatively associated with parent income (r_{pooled} = -0.18, p = .008) and quality of life (r_{pooled} = -0.43, p < .001). Stigma did not vary between males and females (t_{pooled} = 0.33, p = .740, d_{pooled} = 0.04), or as a function of Hispanic/Latino ethnicity (t_{pooled} = -0.55, p = .584, d_{pooled} = -0.11), racial identification (F [6, 228] range 0.87 to 0.93, all p's ≥ 0.477), country of recruitment (F [9, 225] range 0.94 to 0.96, all p's ≥ 0.473), or prior OCD therapy history (t_{pooled} = 1.80, p = .072, d_{pooled} = 0.32). Stigma was observed to be greater among those with prior history of psychotropic medication use, relative to those without this history (t_{pooled} = 3.15, p = .002, d_{pooled} = 0.44).

3.3. Predictors of stigma

Table 3 overviews findings of the linear regression predicting total stigma score. Across imputations, all models were statistically significant (F[12,222] range 10.40 to 11.05, all p < .001), and between 36 to 37% of the variance in stigma was explained by predictors. Depression symptoms emerged as a positive predictor of stigma with a large effect size (β_{pooled} = 0.52, p < .001), and OCD symptom severity emerged as a positive predictor with a small effect size (β_{pooled} = 0.14, p = .017). No other individual variable emerged as a statistically significant predictor.

Table 2
Extent of stigma endorsed.

PROMIS Stigma scale item	*n*	*M* (*SD*)	95% CI of *M*	% endorsing *sometimes* or greater	% endorsing *often* or greater
1. Because of my OCD, others my age avoided me.	235	1.87 (1.08)	[1.72, 2.02]	27.2	9.8
2. Because of my OCD, I felt left out of things	234	2.25 (1.27)	[2.08, 2.42]	43.0	20.0
3. Because of my OCD, others my age made fun of me.	232	1.88 (1.16)	[1.72, 2.04]	26.4	10.6
4. Because of my OCD, I felt embarrassed when I was in front of others my age.	234	2.29 (1.24)	[2.12, 2.46]	40.4	20.4
5. Because of my OCD, I was treated unfairly by others my age.	234	1.70 (1.05)	[1.56, 1.84]	20.9	10.2
6. Because of my OCD, others my age tended to ignore my good points.	233	1.83 (1.14)	[1.67, 1.99]	24.3	11.5
7. Because of my OCD, I felt different from others my age.	234	2.71 (1.39)	[2.52, 2.90]	52.8	31.9
8. I avoided making new friends to avoid talking about my OCD.	234	1.93 (1.27)	[1.76, 2.10]	26.0	17.0
Total Score	**231**	**16.41 (7.78)**	**[15.41, 17.41]**	-	-

Note: Item responses are 1 (never), 2 (rarely), 3 (sometimes), 4 (often), 5 (always). Non-imputed data is presented. 95% Confidence Interval of the Mean for the individual items were calculated using the Cousineau-Morey method.

3.4. Stigma predicting psychological outcomes

In the model predicting OCD symptom severity, step 1 predictors accounted for 15 to 17% of the variance in symptom severity across imputations (F [11,223] range 3.40 to 4.27, all p < .001). Step 2, which added stigma, resulted in significantly improved model fit (F_{change} [1,222] range 4.92 to 7.12, all p < .03, all R^2_{change} = 0.02). As an individual predictor, higher stigma was found to be associated with higher OCD severity, with a small effect size (β_{pooled} = 0.14, p = .017). Complete predictor parameters for the final step of this regression are in Supplementary Table 1.

In the model predicting quality of life, explained variance by step 1 predictors ranged from 50 to 52% across imputations (F [12,222] range 18.65 to 19.85, all p < .001). Inclusion of stigma in step 2 did not improve model fit (F_{change} [1,221] range 0.60 to 0.96, all p ≥ .328, all R^2_{change} = 0.00), and stigma was not a unique, significant predictor of quality of life (β_{pooled} = -0.05, p = .400). Complete predictor parameters for the final step of this regression are in Supplementary Table 2.

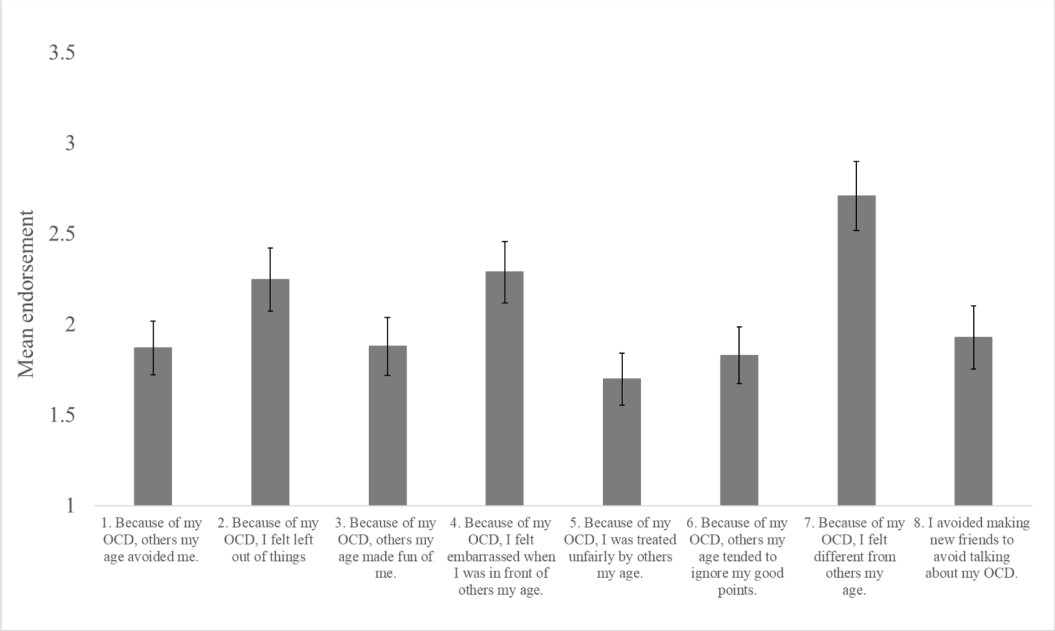

Fig. 1. PROMIS stigma item endorsement.
Note: Item values can range from 1 to 5. Error bars represent within-subject 95% confidence intervals computed using the Cousineau–Morey method.

Table 3
Linear regression coefficients predicting stigma.

Independent Variable	β	*SE*	*t*	*p*
Youth Age	-0.03	0.06	-0.47	.640
Youth Sex	0.07	0.06	1.24	.214
Youth Race	0.01	0.06	0.14	.887
Youth Ethnicity	-0.07	0.06	-1.10	.273
Family Income	-0.09	0.06	-1.47	.141
Country	0.07	0.06	1.20	.232
Number of Comorbid Diagnoses	0.07	0.06	1.19	.234
Prior OCD Therapy	-0.02	0.06	-0.34	.736
Prior Psychotropic Medication	0.07	0.06	1.18	.237
Anxiety Symptomatology	0.00	0.07	0.06	.956
Depression Symptomatology	**0.52**	**0.07**	**7.12**	**<.001**
OCD Severity	**0.14**	**0.06**	**2.38**	**.017**

Note: Presented are pooled coefficients of 25 imputations of ordinary least squares linear regressions predicting stigma as measured by the PROMIS Stigma scale. Regressions explained between 36–37% of the variance in stigma across imputations. All variables were standardized prior to entry, resulting in standardized regression coefficients. Sex coded as 1= male, 0 = female; Race coded as 1= White, 0 = not White; Ethnicity coded as 1 = Latino/Hispanic, 0 = not Latino/Hispanic; Country coded as 1 = USA, 0 = not USA; Prior OCD therapy and prior psychotropic medication coded as 1 = yes, 0 = no. Anxiety and Depression symptomatology are measured by the PROMIS Depression and Anxiety Scales; OCD Severity is measured by the Children's Yale-Brown Obsessive-Compulsive Scale, Second Edition.

Lastly, in the model predicting parent-rated OCD impact, explained variance by step 1 predictors ranged from 34 to 37% (F[12,222] range 9.54 to 11.03, all $p < .001$). Adding stigma in step 2 significantly improved model fit (F_{change} [1,221] range 17.00 to 22.28, all $p < .001$, R^2_{change} range 0.05 to 0.06). Greater stigma was associated with higher-rated impact of OCD, with a near medium effect size ($\beta_{pooled} = 0.29$, $p < 0.001$), and was noted to have the largest effect size of any predictor in the model. Complete predictor parameters for the final step of this regression are in Supplementary Table 3.

4. Discussion

This study represents a novel effort to assess stigma among Latin American youth with OCD across 10 countries. To our knowledge, this is the first study to directly examine experiences of mental health stigma among youth living with any mental illness in a predominantly Latin American sample, and the first quantitative investigation of stigma among youth with OCD. Our findings indicate that stigma is a meaningful challenge in this population, with approximately two-thirds of participants reporting stigma experiences at least "sometimes" and two-fifths endorsing at least one stigma experience "often" or more. These findings are consistent with prior qualitative work indicating that many youth with OCD report concerns related to mental health stigma (Keyes et al., 2018; Khesht-Masjedi et al., 2017; Sravanti et al., 2024; Vallani et al., 2023). Although measurement of stigma has varied substantially across pediatric studies, the overall level of stigma observed here appears comparable to that reported in other research examining youth mental health stigma across North America, Europe, and Asia (Dikeç et al., 2022; Ferrie et al., 2020), further supporting that lived mental health stigma is prevalent across diverse ethnic groups.

Stigma items assessing internalizing experiences (e.g., embarrassment about OCD symptoms in front of peers) showed the highest mean levels of endorsement, whereas externally enacted stigma items (e.g., being treated unfairly by peers) were endorsed less frequently. This pattern is consistent with prior work in both adults and youth with OCD, in which fear of potential stigma is often reported more frequently than direct experiences of discrimination (Fennell & Liberato, 2007; Keyes et al., 2018; Sravanti et al., 2024). The prominence of internalized stigma may also reflect the high prevalence of shame, embarrassment, and guilt in OCD (Glazier & Wetterneck, 2015; Laving et al., 2023), which may facilitate internalization of stigmatizing beliefs. This may be particularly relevant for symptom presentations associated with greater public stigma, such as taboo-related content (McCarty et al., 2017). Adolescents may be especially vulnerable to internalized stigma due to heightened social sensitivity during identity development (DeLuca, 2020; Heary et al., 2017). These findings may also reflect potential cultural beliefs about mental health among Latino individuals, such as fears of being perceived as "crazy", fears of affiliate stigma toward family members, and attributions of mental health difficulties due to character flaws (Mascayano et al., 2016; Misra et al., 2021; Turner et al., 2016).

While several variables were associated with stigma at the univariate

level (including age, psychotropic medication history, income, and number of diagnoses), multivariate analyses indicated that only depressive symptoms and obsessive-compulsive severity independently predicted stigma. Similarly, stigma predicted obsessive-compulsive symptom severity above and beyond other covariates. The strong association between mental health stigma and depression is well established and may reflect shared features such as low self-esteem (O'Donnell & Foran, 2024). The observed association between stigma and OCD severity extends findings from the adult literature (Kaur et al., 2023; Kılıç et al., 2022; Lorona et al., 2018; Ociskova et al., 2021; Picco et al., 2017) to a youth sample and is consistent with stigma–symptom severity links observed in other pediatric mental illness populations (Ferrie et al., 2020). Greater symptom severity may increase both self-awareness of symptoms and visibility of compulsions to others, reinforcing self-stigmatizing beliefs. Symptom severity may also co-occur with factors such as cognitive rigidity, social skill difficulties, emotional dysregulation, and sensory phenomena, which may contribute to social exclusion and stigma. In contrast, the lack of independent associations between sociodemographic and other clinical variables and lived stigma is consistent with mixed findings in the youth literature (Dikeç et al., 2022; Ferrie et al., 2020).

Although stigma was negatively correlated with quality of life in univariate analyses, it did not independently predict quality of life in multivariate models. In contrast, stigma emerged as the strongest individual predictor of parent-rated impact of the child's OCD, even after accounting for symptom severity. One possible explanation for this pattern is differences in construct specificity, informant, and time frame across measures. Stigma was assessed specifically in relation to OCD, and the parent-rated impact measure captured broader, cumulative functional impacts of OCD across domains, whereas the PQ-LES-Q was child-rated and reflected current overall functioning. In this population, stigma-related experiences may therefore be more closely linked to broader, longer-term illness-related functional burden than to momentary perceptions of quality of life. Another consideration is the strong overlap between depression and stigma; depression was the strongest independent predictor of quality of life; thus, depressive symptoms may have accounted for much of the variance in quality of life that might otherwise be attributed to stigma. Stigma may also influence functioning through pathways not fully captured by global quality of life measures. Prior research in youth and Latino populations suggests stigma is associated with avoidance, social withdrawal, secrecy, relational difficulties, and shame (Ferrie et al., 2020; Misra et al., 2021), which may contribute to functional impairment over time. Nevertheless, these findings suggest stigma may be clinically relevant to pediatric OCD treatment, where improving symptoms and functioning are central goals. Prior adult OCD studies indicate that higher baseline self-stigma (Ociskova et al., 2021) and smaller reductions in self-stigma (Lorona et al., 2018) predict poorer treatment outcomes, highlighting an important direction for future pediatric research.

The findings of this investigation should be considered alongside the study's limitations. First, the cross-sectional design precludes causal inference. The study focused exclusively on youth-reported stigma, although parent stigma has also been identified as a treatment barrier, particularly among ethnic minority families (Kolvenbach et al., 2018). Youth and parent stigma likely interact to influence treatment utilization and psychological outcomes, which was a nuance not captured in this study. The sample also included a high proportion of youth with prior treatment history, likely reflecting that recruitment occurred predominately through OCD treatment centers, and may therefore underrepresent youth who are unable or unwilling to seek care and may be at highest risk of stigma (Cheesmond et al., 2019; Ferrie et al., 2020), potentially leading to an underestimation of stigma in this population. Variation in recruitment methods across sites may have introduced additional selection bias within our sample, further limiting generalizability. This study also did not assess relevant constructs including ethnic identity and acculturation, which may contribute to variability in stigma experiences. Finally, although the stigma measure used was validated (Molina et al., 2013), it was not specifically developed for Latin American populations and may not fully capture culturally salient aspects of stigma (e.g., fears of being viewed as crazy or weak, impact on families; Turner et al. 2016). The measure also did not directly assess stigma related to seeking mental health treatment, which is related to but distinct from stigma of having a mental illness (Tucker et al., 2013).

Further research is needed to better understand stigma experiences among Latin American youth with a broader range of mental illnesses. Stigma as a barrier to treatment may be more fully characterized through purposive sampling of youth who have not yet sought care or who are at elevated risk for stigma. Within OCD specifically, future studies should examine longitudinal predictors and outcomes of stigma, particularly in relation to treatment response. The interaction between parent and youth stigma toward OCD also warrants further investigation, especially in Latin American populations. Incorporating perspectives from additional stakeholders (e.g., parents, teachers) and examining the intersection of cultural beliefs and other forms of discrimination with mental health stigma would provide a more comprehensive understanding of stigma experiences among Latin American youth and other populations. Collectively, these directions will be critical for informing the development and cultural tailoring of stigma-reduction interventions for pediatric OCD and youth mental health more broadly in Latin American populations.

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Study procedures were reviewed and approved by the Baylor College of Medicine IRB (H-49814). Each participating foreign international site received ethical approval from the presiding ethics committee at their institution to implement the harmonized protocol described in Crowley et al. (2024).

Data availability

The data that supports the findings of this study are available from the corresponding author, ES, upon reasonable request.

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Ryan J. McCarty: Writing – review & editing, Writing – original draft, Visualization, Methodology, Formal analysis, Data curation, Conceptualization. **Matias Jensen:** Writing – review & editing, Writing – original draft, Resources, Investigation. **Elissa Paz Jensen Santa Cruz:** Writing – review & editing, Resources, Investigation. **Melisa N. Sagarnaga:** Writing – review & editing, Resources, Investigation. **Pamela Claisse Quiroz:** Writing – review & editing, Resources, Investigation. **Tomás Miño:** Writing – review & editing, Resources, Investigation. **Paola Giusti-Rodriguez:** Writing – review & editing, Resources, Investigation. **Mayra C. Martinez Mallen:** Writing – review & editing, Resources, Investigation. **Maria B. Moyano:** Writing – review & editing, Resources, Investigation. **Dayan Berrones:** Writing – review & editing, Project administration, Investigation, Data curation. **Jacey L. Anderberg:** Writing – review & editing, Project administration, Investigation. **Renee M. Frederick:** Writing – review & editing, Project administration, Investigation. **Hannah C. Moore:** Writing – review & editing, Project administration, Investigation. **Josselyn S. Muñoz:** Writing – review & editing, Project administration, Investigation. **Vanessa Zavala Cruz:** Writing – review & editing, Project administration, Investigation. **Ogechi C. Onyeka:** Writing – review & editing, Project administration, Methodology, Investigation. **Andrew D. Wiese:** Writing – review & editing, Project administration, Methodology, Investigation. **James J. Crowley:** Writing – review & editing, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition. **Eric A. Storch:** Writing – review & editing, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition.

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References

Anholt, G.E., Aderka, I.M., van Balkom, A.J.L.M., Smit, J.H., Schruers, K., van der Wee, N.J.A., Eikelenboom, M., Luca, V.D., van Oppen, P., 2014. Age of onset in obsessive–compulsive disorder: admixture analysis with a large sample. Psychol. Med. 44 (1), 185–194. https://doi.org/10.1017/S0033291713000470.

Baguley, T., 2012. Calculating and graphing within-subject confidence intervals for ANOVA. Behav. Res. 44, 158–175. https://doi.org/10.3758/s13428-011-0123-7.

Belloch, A., Del Valle, G., Morillo, C., Carrió, C., Cabedo, E., 2009. To seek advice or not to seek advice about the problem: the help-seeking dilemma for obsessive-compulsive disorder. Soc. Psychiatry Psychiatr. Epidemiol. 44 (4), 257–264. https://doi.org/10.1007/s00127-008-0423-0.

Cheesmond, N.E., Davies, K., Inder, K.J., 2019. Exploring the role of rurality and rural identity in mental health help-seeking behavior: a systematic qualitative review. J. Rural Ment. Health 43 (1), 45–59. https://doi.org/10.1037/rmh0000109.

Coluccia, A., Ferretti, F., Fagiolini, A., Pozza, A., 2017. Quality of life in children and adolescents with obsessive–compulsive disorder: a systematic review and meta-analysis. Neuropsychiatr. Dis. Treat. 13, 597–608. https://doi.org/10.2147/NDT.S122306.

Cohen, J., 1988. Statistical Power Analysis For the Behavioral Sciences, 2nd ed. Routledge, New York. https://doi.org/10.4324/9780203771587.

Crowley, J.J., Cappi, C., Ochoa-Panaifo, M.E., Frederick, R.M., Kook, M., Wiese, A.D., Rancourt, D., Atkinson, E.G., Giusti-Rodriguez, P., Anderberg, J.L., , Latin American Trans-ancestry INitiative for OCD genomics, Brazilian Obsessive-Compulsive Spectrum Disorder Working GroupStorch, E.A., 2024. Latin American trans-ancestry initiative for OCD genomics (LATINO): study protocol. Am. J. Med. Genet. B Neuropsychiatr. Genet. 195 (4), e32962. https://doi.org/10.1002/ajmg.b.32962.

DeLuca, J.S., 2020. Conceptualizing adolescent mental illness stigma: youth stigma development and stigma reduction programs. Adolesc. Res. Rev. 5 (2), 153–171. https://doi.org/10.1007/s40894-018-0106-3.
Dikeç, G., Bilaç, Ö., Kardelen, C., Sapmaz, Ş.Y., Kandemir, H., 2022. Which factors affect internalized stigmatization in adolescents with mental disorders? J. Clin. Child Adolesc. Psychiatr. Nurs. 35 (4), 362–371. https://doi.org/10.1111/jcap.12391.
Endicott, J., Nee, J., Yang, R., Wohlberg, C., 2006. Pediatric quality of life enjoyment and satisfaction questionnaire (PQ-LES-Q): reliability and validity. J. Am. Acad. Child Adolesc. Psychiatry 45 (4), 401–407. https://doi.org/10.1097/01.chi.0000198590.38325.81.
Fawcett, E.J., Power, H., Fawcett, J.M., 2020. Women are at greater risk of OCD than men: a meta-analytic review of OCD prevalence worldwide. J. Clin. Psychiatry 81 (4), 13075. https://doi.org/10.4088/JCP.19r13085.
Fennell, D., Liberato, A., 2007. Learning to live with OCD: labeling, the self, and stigma. Deviant Behav. 28 (4), 305–331. https://doi.org/10.1080/01639620701233274.
Ferrie, J., Miller, H., Hunter, S.C., 2020. Psychosocial outcomes of mental illness stigma in children and adolescents: a mixed-methods systematic review. Child. Youth Serv. Rev. 113, 104961. https://doi.org/10.1016/j.childyouth.2020.104961.
Fox, A.B., Earnshaw, V.A., Taverna, E.C., Vogt, D., 2018. Conceptualizing and measuring mental illness stigma: the mental illness stigma framework and critical review of measures. Stigma Health 3 (4), 348–376. https://doi.org/10.1037/sah0000104.
Gearing, R.E., Washburn, M., Brewer, K.B., Cabrera, A., Yu, M., Torres, L.R., 2024. Pathways to mental health care: Latinos' help-seeking preferences. J. Lat. Psychol. 12 (1), 1–17. https://doi.org/10.1037/lat0000237.
Glazier, K., Wetterneck, C., Singh, S., Williams, M.T., 2015. Stigma and shame as barriers to treatment for obsessive-compulsive and related disorders. J. Depress. Anxiety 4 (3). https://doi.org/10.4172/2167-1044.1000191.
Harris, P.A., Taylor, R., Minor, B.L., Elliott, V., Fernandez, M., O'Neal, L., McLeod, L., Delacqua, G., Delacqua, F., Kirby, J., Duda, S.N., 2019. The REDCap consortium: building an international community of software platform partners. J. Biomed. Inform. 95, 103208. https://doi.org/10.1016/j.jbi.2019.103208.
Harris, P.A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., Conde, J.G., 2009. Research electronic data capture (REDCap)—a metadata-driven methodology and workflow process for providing translational research informatics support. J. Biomed. Inform. 42 (2), 377–381. https://doi.org/10.1016/j.jbi.2008.08.010.
Heary, C., Hennessy, E., Swords, L., Corrigan, P., 2017. Stigma towards mental health problems during childhood and adolescence: theory, research and intervention approaches. J. Child. Fam. Study 26 (11), 2949–2959. https://doi.org/10.1007/s10826-017-0829-y.
Kaur, R., Garg, R., Raj, R., 2023. Quality of life among patients with obsessive compulsive disorder: impact of stigma, severity of illness, insight, and beliefs. Ind. Psychiatry J. 32 (1), 130. https://doi.org/10.4103/ipj.ipj_22_22.
Kaushik, A., Kostaki, E., Kyriakopoulos, M., 2016. The stigma of mental illness in children and adolescents: a systematic review. Psychiatry Res. 243, 469–494. https://doi.org/10.1016/j.psychres.2016.04.042.
Keyes, C., Nolte, L., Williams, T.I., 2018. The battle of living with obsessive compulsive disorder: a qualitative study of young people's experiences. Child Adolesc. Ment. Health 23 (3), 177–184. https://doi.org/10.1111/camh.12216.
Khesht-Masjedi, M.F., Shokrgozar, S., Abdollahi, E., Golshahi, M., Sharif- Ghaziani, Z., 2017. Exploring social factors of mental illness stigmatization in adolescents with mental disorders. J. Clin. Diagn. Res. (11), VC01–VC04. https://doi.org/10.7860/JCDR/2017/27906.10832.
Kılıç, A., Görmez, A., Yeni Elbay, R., Özer, B.U., 2022. Internalized stigma in obsessive compulsive disorder: correlates and associations with quality of life. Arch. Psychiatr. Nurs. 39, 37–45. https://doi.org/10.1016/j.apnu.2022.03.006.
Kolvenbach, S., Fernández de la Cruz, L., Mataix-Cols, D., Patel, N., Jassi, A., 2018. Perceived treatment barriers and experiences in the use of services for obsessive–compulsive disorder across different ethnic groups: a thematic analysis. Child Adolesc. Ment. Health 23 (2), 99–106. https://doi.org/10.1111/camh.12197.
Laving, M., Foroni, F., Ferrari, M., Turner, C., Yap, K., 2023. The association between OCD and shame: a systematic review and meta-analysis. Br. J. Clin. Psychol. 62 (1), 28–52. https://doi.org/10.1111/bjc.12392.
Lenhard, F., Aspvall, K., Andersson, E., Ahlen, J., Serlachius, E., Lavner, M., Brodin, A., Mataix-Cols, D., 2023. The cost of obsessive–compulsive disorder in Swedish youth. Child Psychiatry Hum. Dev. 54 (1), 248–254. https://doi.org/10.1007/s10578-021-01261-z.
López, D., Ochoa, D., Romero, M., Parr, K., 2020. Integrating Latinx/Hispanic culture, traditions, and beliefs into effective school psychology practice. Communique 49 (4), 16–18, 1.
Lorona, R.T., Fergus, T.A., Valentiner, D.P., Miller, L.M., McGrath, P.B., 2018. Self-stigma and etiological attributions about symptoms among individuals diagnosed with an anxiety disorder: relations with symptom severity and symptom improvement following CBT. J. Soc. Clin. Psychol. 37 (7), 536–557. https://doi.org/10.1521/jscp.2018.37.7.536.
Marques, L., LeBlanc, N.J., Weingarden, H.M., Timpano, K.R., Jenike, M., Wilhelm, S., 2010. Barriers to treatment and service utilization in an internet sample of individuals with obsessive-compulsive symptoms. Depress. Anxiety 27 (5), 470–475. https://doi.org/10.1002/da.20694.
Mascayano, F., Tapia, T., Schilling, S., Alvarado, R., Tapia, E., Lips, W., Yang, L.H., 2016. Stigma toward mental illness in Latin America and the Caribbean: a systematic review. Braz. J. Psychiatry 38, 73–85. https://doi.org/10.1590/1516-4446-2015-1652.
McCarty, R.J., Guzick, A.G., Swan, L.K., McNamara, J.P., 2017. Stigma and recognition of different types of symptoms in OCD. Journal of Obsessive-Compulsive and Related Disorders 12, 64–70. https://doi.org/10.1016/j.jocrd.2016.12.006.
Micali, N., Heyman, I., Perez, M., Hilton, K., Nakatani, E., Turner, C., Mataix-Cols, D., 2010. Long-term outcomes of obsessive–compulsive disorder: follow-up of 142 children and adolescents. Br. J. Psychiatry 197 (2), 128–134. https://doi.org/10.1192/bjp.bp.109.075317.
Misra, S., Jackson, V.W., Chong, J., Choe, K., Tay, C., Wong, J., Yang, L.H., 2021. Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: implications for interventions. Am. J. Community Psychol. 68 (3–4), 486–512. https://doi.org/10.1002/ajcp.12516.
Molina, Y., Choi, S.W., Cella, D., Rao, D., 2013. The Stigma scale for chronic illnesses 8-item version (SSCI-8): development, validation and use across neurological conditions. Int. J. Behav. Med. 20 (3), 450–460. https://doi.org/10.1007/s12529-012-9243-4.
Morris, O.J., Wiese, A.D., Pinciotti, C.M., Pacheco, R., Mallen, M.C.M., Schweissing, E.J., Soileau, K.J., Crowley, J.J., Storch, E.A., 2024. Obsessive-compulsive disorder among individuals of Hispanic and Latin American ancestry: cultural considerations for assessment and psychotherapy. Bull. Menninger Clin. 88 (2), 148–170. https://doi.org/10.1521/bumc.2024.88.2.148.
National Museum of the American Latino, 2024. Latinos & Latinas in the US. National Museum of the American Latino. Retrieved August 20, 2024, from. https://latino.si.edu/learn/latino-history-and-culture/latino-history/latinos-latinas-us.
Ociskova, M., Prasko, J., Vanek, J., Holubova, M., Hodny, F., Latalova, K., Kantor, K., Nesnidal, V., 2021. Self-stigma and treatment effectiveness in patients with SSRI Non-responsive obsessive-compulsive disorder. Psychol. Res. Behav. Manag. 14, 85–97. https://doi.org/10.2147/PRBM.S287419.
O'Donnell, A.T., Foran, A.M., 2024. The link between anticipated and internalized stigma and depression: a systematic review. Soc. Sci. Med. 349, 116869. https://doi.org/10.1016/j.socscimed.2024.116869.
Picco, L., Lau, Y.W., Pang, S., Abdin, E., Vaingankar, J.A., Chong, S.A., Subramaniam, M., 2017. Mediating effects of self-stigma on the relationship between perceived stigma and psychosocial outcomes among psychiatric outpatients: findings from a cross-sectional survey in Singapore. BMJ Open 7 (8), e018228. https://doi.org/10.1136/bmjopen-2017-018228.
Quinn, H., Thissen, D., Liu, Y., Magnus, B., Lai, J.-S., Amtmann, D., Varni, J.W., Gross, H. E., DeWalt, D.A., 2014. Using item response theory to enrich and expand the PROMIS® pediatric self report banks. Health Qual. Life Outcomes 12 (1), 160. https://doi.org/10.1186/s12955-014-0160-x.
Rubin, D.B., 1987. Multiple Imputation for Nonresponse in Surveys. John Wiley & Sons Inc., New York https://doi.org/10.1002/9780470316696.
Sheehan, D.V., Sheehan, K.H., Shytle, R.D., Janavs, J., Bannon, Y., Rogers, J.E., Milo, K. M., Stock, S.L., Wilkinson, B., 2010. Reliability and validity of the mini international neuropsychiatric interview for children and adolescents (MINI-KID). J. Clin. Psychiatry 71 (3), 17393. https://doi.org/10.4088/JCP.09m05305whi.
Storch, E.A., McGuire, J.F., Wu, M.S., Hamblin, R., McIngvale, E., Cepeda, S.L., Schneider, S.C., Rufino, K.A., Rasmussen, S.A., Price, L.H., Goodman, W.K., 2019. Development and psychometric evaluation of the children's Yale-Brown Obsessive-Compulsive Scale second edition. J. Am. Acad. Child Adolesc. Psychiarty 58 (1), 92–98. https://doi.org/10.1016/j.jaac.2018.05.029.
Storch, E.A., Rasmussen, S.A., Price, L.H., Larson, M.J., Murphy, T.K., Goodman, W.K., 2010. Development and psychometric evaluation of the Yale–Brown obsessive-compulsive scale—second edition. Psychological assessment 22 (2), 223. https://doi.org/10.1037/a0018492.
Storch, E.A., Small, B.J., McGuire, J.F., Murphy, T.K., Wilhelm, S., Geller, D.A., 2018. Quality of life in children and youth with obsessive-compulsive disorder. J. Child Adolesc. Psychopharmacol. 28 (2), 104–110. https://doi.org/10.1089/cap.2017.0091.
Sravanti, L., Madegowda, R.K., Velusamy, A.J.P., Kommu, J.V.S., Girimaji, S.C., Seshadri, S., 2024. Navigating recovery in childhood OCD: a qualitative analysis of barriers and facilitators. Child Adolesc. Psychiatry Ment. Health 18 (160). https://doi.org/10.1186/s13034-024-00851-8.
Strouphauer, E.R., Morris, O.J., Soileau, K.J., Wiese, A.D., Quast, T., Goodman, W.K., Sheth, S.A., Wojcik, K.D., Guzick, A.G., Storch, E.A., 2023. Economic analyses of obsessive-compulsive disorder interventions: a systematic review. PharmacoEconomics 41 (5), 499–527. https://doi.org/10.1007/s40273-023-01250-1.
Tolin, D.F., Gilliam, C., Wootton, B.M., Bowe, W., Bragdon, L.B., Davis, E., Hannan, S.E., Steinman, S.A., Worden, B., Hallion, L.S., 2018. Psychometric properties of a structured diagnostic interview for DSM-5 anxiety, mood, and obsessive-compulsive and related disorders. Assessment 25 (1), 3–13. https://doi.org/10.1177/1073191116638410.
Trompeter, N., Johnco, C., Zepeda-Burgos, R.M., Schneider, S.C., Cepeda, S.L., La Buissonnière-Ariza, V., Guttfreund, D., Storch, E.A., 2022. Mental health literacy and stigma among salvadorian youth: anxiety, depression and obsessive-compulsive related disorders. Child Psychiatry Hum. Dev. 53 (1), 48–60. https://doi.org/10.1007/s10578-020-01096-0.
Tucker, J.R., Hammer, J.H., Vogel, D.L., Bitman, R.L., Wade, N.G., Maier, E.J., 2013. Disentangling self-stigma: are mental illness and help-seeking self-stigmas different? J. Couns. Psychol. 60 (4), 520–531. https://doi.org/10.1037/a0033555.
Turner, E.A., Cheng, H.-L., Llamas, J.D., Tran, A.G.T.T., Hill, K.X., Fretts, J.M., Mercado, A., 2016. Factors impacting the current trends in the use of outpatient

psychiatric treatment among diverse ethnic groups. Curr. Psychiatry Rev. 12 (2), 199–220. https://doi.org/10.2174/1573400512666160216234524.

Vallani, T.I., Naqqash, Z., Lin, B., Lu, C., Austin, J.C., Stewart, S.E., 2023. The journey from concealment to disclosure of an obsessive-compulsive disorder diagnosis in the high school setting: a qualitative study exploring youth perspectives. Psychiatry Res. 326, 115275. https://doi.org/10.1016/j.psychres.2023.115275.

Williams, M.T., Domanico, J., Marques, L., Leblanc, N.J., Turkheimer, E., 2012. Barriers to treatment among African Americans with obsessive-compulsive disorder. J. Anxiety Disord. 26 (4), 555–563. https://doi.org/10.1016/j.janxdis.2012.02.009.

Wetterneck, C.T., Little, T.E., Rinehart, K.L., Cervantes, M.E., Hyde, E., Williams, M., 2012. Latinos with obsessive-compulsive disorder: mental healthcare utilization and inclusion in clinical trials. J. Obsessive Compuls. Relat. Disord. 1 (2), 85–97. https://doi.org/10.1016/j.jocrd.2011.12.001.