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Obsessive-compulsive disorder among individuals of Hispanic and Latin American ancestry: Cultural considerations for assessment and psychotherapy

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Research specific to obsessive-compulsive disorder (OCD) among individuals of Hispanic and Latin American (H/L) ancestry is limited, as are culturally relevant assessment and treatment recommendations. This article discusses the implications of underrepresentation of H/L populations in OCD research and emphasizes the need to consider issues related to assessment,

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Supplementary materials are available online.

Nota: El resumen también estará disponible en español en línea.

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treatment, and structural barriers that hinder delivery of culturally appropriate first-line psychotherapy. Recommendations for assessment and treatment are provided to aid clinicians in distinguishing culturally normative thoughts and behaviors from OCD, as well as to inform the implementation of psychotherapeutic interventions with cultural humility. This manuscript offers recommendations for future research to tackle health equity concerns with respect to assessment and treatment and structural factors limiting access to culturally appropriate psychotherapy. Wide-scale efforts are needed to comprehensively understand how H/L cultures intersect with various OCD presentations and to further disseminate treatments to populations that have historically lacked access to mental health care. (*Bulletin of the Menninger Clinic, 88*[2]*, 148–170*)

Keywords: obsessive-compulsive disorder, Hispanic, Latino, cultural sensitivity, health equity, treatment, structural barriers

Introduction

Literature specific to obsessive-compulsive disorder (OCD) among individuals of Hispanic and Latin American (H/L) ancestry is limited. Persons of H/L ancestry represent many groups with distinct histories, cultures, and experiences spanning regions such as Mexico, Central and South America, and the Caribbean, as well as their diaspora that have since moved across the globe. Addressing all the diverse cultures under the umbrella of Hispanic and Latin American is not possible; however, the present text seeks to highlight clinical considerations for assessment and intervention for those working with individuals with OCD from H/L backgrounds.

OCD is a heterogenous condition characterized by the presence of unwanted and recurrent intrusive thoughts (obsessions) and/or safety and avoidance behaviors (compulsions) that are designed to neutralize obsessional distress (American Psychiatric Association, 2022; Bragdon & Coles, 2017). Specific obsessions and compulsions differ among individuals. However, common symptom domains include concerns of symmetry with compulsive ordering and arranging; contamination with compulsive washing/cleaning; doubt and harm with compulsive checking behaviors; and taboo obsessions of sexual/aggressive

themes with corresponding compulsions, including avoidance and checking (Bloch et al., 2008; Perez et al., 2022; M. T. Williams et al., 2017).

Rates of OCD are consistent across biological sexes, and symptom onset is typically seen in childhood (de Mathis et al., 2008; Sasson et al., 1997; Weissman et al., 1994). When left untreated, OCD often worsens, resulting in significant impairment in functioning (Jakubovski et al., 2013). Although OCD has been observed across cultures and nationalities, OCD prevalence research involving H/L populations has been limited thus far (Nicolini et al., 2017; Pampaloni et al., 2022).

There are a few studies that report OCD epidemiological rates among H/L persons (see Table 1); however, diverse methodologies and inclusion criteria make it difficult to compare rates across them and likely to contribute to inconsistencies. For example, Karno et al. (1989) found no significant differences in OCD prevalence for non-Hispanic Caucasian and Mexican American people in the U.S., while Weissman et al. (1994) reported a lower prevalence of OCD in non-Hispanic Caucasian (1.3% annual) compared to Puerto Rican (1.8% annual) people. These rates are substantially lower than what has been reported in Colombia, with one study suggesting prevalence rates as high as 7.4% among adolescents (Navarro-Mancilla et al., 2011). With differing methodologies and limited recent studies assessing prevalence among H/L population, additional research is certainly needed.

While existing cross-cultural studies provide some insight into the prevalence of OCD among those of H/L ancestry, there remain knowledge gaps in how symptomology and treatment may be influenced by these cultures. Environmental factors, including a given culture, can contribute to the ways in which OCD symptoms present (Taylor & Jang, 2011; Tramonti et al., 2021; M. T. Williams et al., 2017). However, empirically derived clinical recommendations are lacking due to the limited representation of H/L individuals in OCD research, with estimates as low as 1% of participants in OCD clinical trials identifying as H/L (Wetterneck et al., 2012; Williams et al., 2010). Moreover, those of H/L backgrounds have greater difficulties accessing appropriate care compared to other populations (Cabassa et al., 2006) and are disproportionally more likely to be undertreated

Table 1. OCD prevalence rate by study and country

Author	Year	Assessment Measure(s)	Region		Prevalence Rate	
			Country	City	Annual Cases/100 People (*SE*)	Lifetime Cases/100 (*SE*)
Caraveo-Anduaga & Bermúdez	2004	Composite International Diagnostic Interview (CIDI) with OCD section from WHO-CIDI 1.1	Mexico	Mexico City	1.0 (NR)[a]	1.4 (NR)
Karno et al.	1989	*Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*)	United States	Baltimore	2.2 (0.3)	3.0 (0.3)
				Los Angeles	0.8 (0.1)	2.1 (0.3)
				New Haven	1.6 (0.3)	2.5 (0.4)
				Piedmont	2.3 (0.4)	3.3 (0.5)
				St. Louis	1.4 (0.3)	1.9 (0.3)
				All 5 cities (ECAs)[b] combined	1.6 (0.2)	2.5 (0.2)
Navarro-Mancilla et al.	2011	Structured Clinical Interview for DSM-IV	Colombia	Bucaramanga	NR	7.4 (1.19)
Vicente et al.	2006	Approved Spanish version of CIDI 1.0 and 1.1	Chile	Combined: Concepción, Santiago, Iquique, and Cautín	1.2 (0.6)	1.2 (0.6)
Wetterneck et al.	2012	Spanish translation of Diagnostic Interview Schedule (DIS)	U.S. (Puerto Rico only)	—	NR	3.5 (0.2)
Wiessman et al.	1994	DIS with DSM-III for schizophrenia exclusion	Canada	Edmonton	1.4 (0.25)	2.3 (0.32)
			Germany	Munich	1.6 (0.57)	2.1 (0.66)
			Korea	—	1.9 (0.21)	1.1 (0.17)
			Taiwan	—	0.4 (0.07)	0.7 (0.10)
			New Zealand	—	1.1 (0.31)	2.2 (0.42)
			Puerto Rico,	—	1.8 (0.39)	2.5 (0.46)
			USA[c]	Combined: 5 ECAs above	1.3 (0.11)	2.3 (0.15)

[a]NR = not reported; [b]ECA = epidemiologic catchment area; [c]Puerto Rico is a U.S. Commonwealth, not a country as was defined in Wiessman et al. (1994).

in health care settings due to several overlapping structural factors, including access to health care, insurance status, language, cultural, and financial barriers (Flores & Vega, 1998; Green et al., 2020). In the absence of large-scale research efforts specific to OCD in those of H/L ancestry (e.g., Crowley et al., 2023), issues of health equity will persist. Without an understanding of how H/L cultures influence OCD presentation and access to care through treatment-seeking behaviors, symptom expression, and responses to treatment, H/L persons may experience delays in diagnosis or treatment and may receive suboptimal care when treatment is obtained.

Cultural considerations in conceptualization

From a cognitive perspective, OCD is theorized to develop from misappraisals of normal intrusive thoughts based on dysfunctional beliefs (Julien et al., 2007; Rachman, 1997; Williams et al., 2017). What differentiates intrusive thoughts in OCD from typical intrusive thoughts among people who do not have OCD is not the content, but rather the response to these thoughts. In fact, seminal work found that there are no differences in the content themes present in intrusive thoughts within and outside OCD. Instead, intrusive thoughts are more likely to become obsessive when the thought is believed to be dangerous and personally relevant, that it must be controlled, and that the individual having the intrusive thought is responsible for preventing the feared catastrophic outcome (Purdon & Clark, 1993; Radomsky et al., 2014). Paradoxically, efforts to suppress and neutralize intrusive thoughts using compulsions only serve to intensify their emotional valence and the likelihood of compulsions recurring, thus maintaining the cycle of obsessions and compulsions.

Culture may influence the theme and content of obsessive thoughts in people with OCD (Matsunaga & Seedat, 2007), shaping which intrusive themes feel personally relevant (e.g., associated with the values of a given culture) and most distressing. Social and cultural phenomena such as religious rituals, views about sexuality, political uncertainty, and responses to the AIDS epidemic and COVID-19 pandemic have all been

found to influence OCD presentation (Bruce & Stevens, 1992; Linde et al., 2022). Indeed, differences in OCD presentation have been documented across multiple cultures (Gureje et al., 2020; Williams et al., 2017). For example, conservative Muslims diagnosed with OCD in Saudi Arabia, compared to British and Hindu samples, report a higher incidence of OCD symptoms relating to religious themes such as obsessions concerning prayers and washing (50%), contamination (41%), and faith (34%), likely reflective of a religious practice called *al-woodo* that involves systematic cleaning of the body before prayer (Mahgoub & Abdel-Hafeiz, 1991).

Few researchers have studied the cultural influences on OCD symptomatology in H/L communities. Research assessing OCD among individuals living in Rio de Janeiro, Brazil, found that aggressive obsessions were endorsed most often (69.7%), followed by contamination (53.5%; Fontenelle et al., 2004). This is a noteworthy disparity given that contamination obsessions tend to present most commonly in other cultures (Matsunaga et al., 2008). The authors theorized that the significant rise in mortality and morbidity resulting from violent causes, partially as a function of accelerated urbanization in the region, may have increased engagement in behaviors intended to avoid violence and harm (Fontenelle et al., 2004). Conceptually, legitimate safety fears in Rio de Janeiro (e.g., car accidents, violent crime, etc.) may generalize and become exaggerated, leading to excessive engagement in compulsions intended to preserve safety. These compulsions reinforce the distorted expectation of danger, increase the emotional valence and frequency of intrusive aggression-related thoughts, and increase dependence on compulsions as a means of coping with these thoughts and their associated anxiety.

Differences in OCD symptomatology among U.S. Caucasian and Mexican university students have also been observed, with Mexican university students reporting greater overall OCD symptom severity and severity across different symptom domains, including contamination, responsibility for harm, unacceptable/taboo thoughts, and symmetry (Berman et al., 2020). Additionally, spirituality was identified as a protective factor against OCD symptom severity in Mexican but not U.S.

university students. The authors suggested that the differences in the protective effect of spirituality may be due to higher levels of familial support among religious and spiritual Mexicans, but not their U.S. counterparts. This suggests that although symptom severity may be elevated in Mexico relative the U.S., spirituality and religion may function differently in these populations due to unique cultural influences.

A study comparing OCD presentation between U.S. Caucasians and Costa Ricans found that it was not the symptom themes that differed but rather the distress and functional impairment caused by obsessions and compulsions (Chavira et al., 2008). Costa Ricans reported lower OCD-related impairment and perceived distress compared to U.S. Caucasians. The authors theorized there were fewer psychosocial stressors in the primarily agrarian region of Costa Rica from which the sample was derived, and stressors could be avoided so as not to impair an individual's life. For example, the authors described an individual who didn't drive due to a fear of hurting someone, yet this fear was not problematic for the individual because they could easily walk places or rely on family members to help with transportation. Thus, what is conceptualized as dysfunctional or functionally impairing is not universal across cultures and depends upon the lifestyle and customs of a given environment.

While these studies do highlight cultural differences that may exist across OCD presentations, future research should examine the role of acculturation, as OCD presentations may differ between those of H/L ancestry living within and outside predominantly H/L countries. This may be particularly relevant in the U.S., where a large portion of the population identifies as H/L, and acculturation may influence how a given culture influences certain OCD presentations. When conceptualizing OCD in H/L populations, it is critical to consider both the impact of cultural values, norms, and experiences on the presentation of OCD symptoms as well as what is truly functionally impairing in a given cultural context. Clinicians, particularly those who are not H/L, should be mindful of not projecting their own values, norms, experiences, and beliefs onto the individual with OCD, which risks over-pathologizing culturally normative beliefs and responses.

Table 2. **Mexican beliefs and customs that may be confused for OCD compulsions**

OCD Theme	Possible Compulsion	Belief and Custom in Mexican Culture
Superstition/ Magical thinking	Avoiding babies during menstruation (e.g., avoiding holding or being near breastfeeding babies).	Proximity to a menstruating person could cause the milk to go dry, or other bad things could happen to the baby.
	Wearing red accessories near pregnant people.	Wearing a red string with a specific number of knots around a pregnant belly will protect the baby during full a moon/ lunar eclipse (e.g., preventing deformities in the development of the fetus). Wearing a red bracelet around a baby will help the baby avoid getting "mal ojo" (picking up negative energy).
	Rubbing an egg on oneself after exposure to something negative or scary.	Rubbing an egg on oneself will help get rid of bad energy, like energy caused by the Evil Eye.
	Rubbing an egg on a crying baby after exposure to the outdoors.	Rubbing an egg on a crying baby will help get rid of the bad energy they picked up from people or places. The baby will stop crying when the egg is cracked.
Contamination	Wash meat, beans, and rice before cooking.	Foods like meat, beans, and rice are washed before cooking because they are dirty and could cause illness.
	Avoiding going outside without shoes or wet hair.	Walking outside without shoes or wet hair will lead to sickness.
Religious	Avoiding a friend's house because they own a Ouija board.	Engaging with a Ouija board will invite evil into one's life. Ouija board is a method of communication with the devil.
	Repeating phrases can cause positive outcomes.	It is common to say "si dios quiere" (it's in God's hands) to bring about positive outcomes.
Harm	Not allowing children to sleep at other people's homes.	Sleepovers are often not allowed, particularly for girls, because "uno nunca sabe" (you never know). A sleepover will lead to the child being molested.

Note. Examples are derived from Mexican customs but may be relevant for other Latin American cultures as well. Examples provided here are based on clinical experiences from the contributing authors.

Cultural considerations in assessment

The defining features of OCD appear to be the same regardless of racial or ethnic identification, and presentations of OCD are observed across international borders (Nicolini et al., 2017). However, failure to apply a culturally informed lens to OCD assessment and conceptualization can lead to misunderstanding and over-pathologizing beliefs and behaviors that may be typical and/or functional in a given culture. As such, OCD assessment should involve careful consideration of the individual's context. To illustrate these considerations, Table 2 provides examples of beliefs, behaviors, and customs that are common in Mexican culture that could be misdiagnosed as OCD symptoms.

It is critical to reduce misdiagnosis because it delays access to appropriate treatments, worsens psychopathology, and perpetuates feelings of shame around obsessive content (Stahnke, 2021). Clinicians should be aware that certain OCD domains may be more prone to cultural variance and therefore may require more careful investigation. Taboo thoughts are often misidentified by both trained mental health providers and primary care physicians and are commonly underrecognized as obsessions (Glazier et al., 2013, 2015; Glazier & McGinn, 2015; Perez et al., 2022). These taboo thoughts can be misconceptualized as a symptom of other mental health conditions, including delusions, which are often seen as psychotic disorders (Stahnke, 2021). Similar OCD misdiagnosis rates for taboo thoughts are found in providers in Latin America and the United States (Perez et al., 2022), suggesting that the propensity for these symptoms to be misdiagnosed persists across different cultures. Still, more research is needed to understand the misdiagnosis rates of taboo symptoms in discordant cultural client-clinician dyads, such as those common in the United States for H/L clients (Takeshita et al., 2020; Zamudio et al., 2017), as cultural misunderstandings may exaggerate existing disparities for the misdiagnosis of taboo symptoms.

To improve the accuracy of OCD assessment for H/L clients, it may be helpful to rely on the criteria of OCD as an extreme belief or action beyond those of the individual's peers. Follow-up questions during assessment with clients can help provide a basis for what is typical and atypical in a given H/L culture.

Because the degree of insight can vary across individuals with OCD, consultation with outside sources (e.g., family members, friends, teachers) may be necessary to ensure the accuracy of reporting of expected and typical behavior. It is also important to consider the role of distress and functional impairment. The *DSM-5-TR* (American Psychiatric Association, 2022) requires that OCD symptoms (1) take more than one hour per day, (2) cause clinically significant distress, and/or (3) cause impairment in important areas of functioning. This means that a superstitious belief and associated behavior common in an individual's culture would not be considered an OCD symptom if it took place in a fleeting moment, was not distressing, and did not impair the individual's functioning.

Conversely, just as standard religious customs can be distorted by scrupulosity themes, clinicians should be aware that the existence of a connection between a fear or behavior and H/L culture does not automatically preclude the possibility that it could be an OCD symptom. Indeed, individuals with OCD from H/L cultures may develop significant distress associated with common cultural fears (e.g., inadvertently harming pregnant people) and engage in excessive or overly ritualized compulsions beyond what would be considered typical in H/L culture (e.g., repeatedly rubbing an egg on oneself for hours on end while neutralizing bad thoughts). Thus, such beliefs and behaviors should be conceptualized on a case-by-case basis with these important nuances in mind.

Lastly, there is currently limited knowledge on how commonly used OCD assessments perform across multiple H/L countries. Some OCD assessment measures have been validated in Mexico and Brazil (Medeiros et al., 2017; Nicolini et al., 1996; Ulloa et al., 2004), although replications are necessary as well as studies to ensure these assessments are similarly valid in other Latin American countries.

Cultural considerations in evidence-based treatment

Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) is the first-line psychotherapeutic treatment for OCD (Ferrando & Selai, 2021; McGuire et al., 2015; Spencer et al., 2023). This intervention involves systematic,

graded exposure to stimuli that trigger obsessive thoughts and corresponding distress while actively resisting compulsive behaviors designed to alleviate distress and prevent the feared outcome from taking place (Hezel & Simpson, 2019; Whittal et al., 2005). ERP is effective for both children and adults and can be delivered both in-person and over telehealth (Ferrando & Selai, 2021; Olatunji et al., 2013; Rees & Maclaine, 2015; Storch et al., 2011). Although third-wave CBT interventions, specifically acceptance and commitment therapy, show initial promise (e.g., Twohig et al., 2015, 2018), the emphasis on exposures within this treatment does appear necessary and essential for effective intervention, suggesting exposure is a key ingredient in effectively treating OCD (Trent et al., 2021).

ERP literature from both Argentina and Brazil provides evidence that ERP is effective for H/L individuals (Cabedo et al., 2010; Gomes et al., 2016; Volpato Cordioli et al., 2003) and that ERP is comparable, and in some cases, superior, to first-line pharmacological treatments for OCD (Belotto-Silva et al., 2012; Sousa et al., 2006). However, clinical trials assessing treatment outcomes for ERP have disproportionally been conducted in European and North American countries (Ferrando & Selai, 2021), and access to ERP remains limited among those living in predominantly H/L nations (Brakoulias et al., 2019), highlighting the need for greater dissemination efforts to expand access to ERP and provide more evidence for the effectiveness of ERP in a variety of H/L cultures.

The mechanisms theorized to underpin effective ERP are not fundamentally changed by culture; however, adept clinicians should be mindful of the unique influence of culture and associated factors on effective delivery of ERP to those of H/L backgrounds. As illustrated in Table 2, beliefs and behaviors that are culturally bound and determined to not be OCD symptoms should not be seen as targets for intervention. Rather, clinicians must be culturally sensitive and work collaboratively with clients to determine relevant treatment targets based on the client's values and customs, not on the clinician's values and customs.

Religion is a salient aspect of H/L cultures that should be considered in OCD treatment, with many individuals identifying as Roman Catholic. In the context of OCD presentations specific to religious scrupulosity, it is imperative that clinicians, especially

those less familiar with Catholicism, work to understand client beliefs consistent with their faith community to tailor ERP effectively (e.g., Abramowitz, 2001). This may include close consultation with clergy from the client's faith community during ERP (Huppert & Siev, 2010; Siev et al., 2022). Consultation with clergy may allow clinicians to: (1) offer psychoeducation on OCD and ERP to a legitimate authority within the client's faith community to further support them in treatment; and (2) aid in understanding what normative beliefs and behaviors are consistent with the client's faith so exposures can effectively be tailored to challenge obsessive concerns. Overcorrection, or exposure to events or behaviors outside of the ordinary to test whether feared outcomes arise (McLean & Brown, 2023), may be challenging with H/L religious scrupulosity presentation, as the actual engagement in sinful acts is inconsistent with their beliefs. Rather, treatment recommendations for ERP suggest clients systematically engage in normative behaviors while accepting the risk they may inadvertently commit a sinful act (Huppert & Siev, 2010; Siev et al., 2022). Thus, through ERP, individuals can engage in behaviors consistent with their beliefs (e.g., attending Mass) while learning how to tolerate distress related to the uncertainty with which they may engage in sinful behaviors. Decisions about whether to involve overcorrection in the context of ERP require collaborative decision-making between clients and clinicians and an understanding of how H/L culture and beliefs may influence treatment targets.

Prior research suggests the perceived stigma of OCD symptoms may function as a barrier to treatment in minority populations, especially when obsessive concerns center around taboo topics (e.g., violent and sexual obsessions; Glazier et al., 2015). Clinicians working with those of H/L backgrounds should be sensitive and offer sufficient psychoeducation to help normalize presenting concerns. Helping clients understand obsessive thoughts are unwanted (ego-dystonic) and not part of their belief system (ego-syntonic) can help improve OCD symptom insight, a provide a foundation by which symptoms can be addressed through ERP (Belloch et al., 2012). Clinicians may also need to be mindful of the various contexts where these obsessive concerns present and tailor exposures appropriately to prevent reinforcing the stigmatization of OCD symptoms.

While clinicians can certainly help in addressing clients own perceived stigma of their OCD symptoms, they are more limited in their ability to influence the stigma of OCD in the client's broader community.

Clinicians should work collaboratively with patients to determine what level of exposure is appropriate in accordance with their individual and cultural background. Rather than encouraging exposure that may exacerbate concerns of stigma, clinicians and clients may benefit from designing exposures that incorporate values-based actions, or exposures that allow clients to engage in behaviors consistent with their values and directed towards achieving a goal while testing whether they can tolerate obsessive concerns (Twohig et al., 2015). For example, it may be iatrogenic to engage in exposures with overcorrection with certain OCD presentations, including sexual orientation OCD, as it may facilitate concerns of stigma and ultimately fracture client-clinician rapport. Treatment should focus on clients engaging in activities within their communities while experiencing obsessive concerns and actively resisting compulsions (e.g., resist engaging in behaviors to provide certainty about sexual orientation).

Family accommodation of OCD symptoms can present as a barrier to effective ERP and serve to maintain symptoms (Merlo et al., 2009), and may be particularly relevant for clients of H/L backgrounds. A recent clinical trial comparing the effectiveness of CBT with varying degrees of family-specific intervention found that ethnicity impacted the effectiveness of treatment among youth with OCD, with ethnic minority youth maintaining moderately severe OCD symptoms in the treatment condition that did not include enhanced family therapy (Peris et al., 2020). This study highlights the importance of family involvement in the treatment of individuals from H/L backgrounds. Multigenerational households are common in H/L communities, increasing opportunities for family accommodation. H/L families may benefit from explicit dialogue about the various ways family members may inadvertently perpetuate OCD symptomology (Albert et al., 2017; Keene & Batson, 2010). Clinicians might provide psychoeducational materials for a variety of family members, including parents, grandparents, partners/spouses, siblings, and children, and work with clients and their

families to collaboratively discontinue compulsive behaviors involving others (e.g., family cleaning certain objects on the client's behalf). Additionally, multilingual households may necessitate translation services so that all family members can be made aware of how family accommodation feeds OCD symptoms.

Clinicians should also be aware that in H/L cultures, parents' and family members' opinions can carry a great deal of weight, so it is not uncommon to seek approval from relatives in decision-making for a wide variety of scenarios. A clinician may misunderstand such interactions as reassurance seeking and family accommodation. Thus, clinicians should seek to understand the function and presentation of this behavior. If the approval seeking is rooted in pathological doubt and is associated with significant anxiety, it may be OCD-related reassurance seeking; however, if the approval seeking is rooted in respect for one's family or elders and is not associated with significant anxiety, it is likely to be normative behavior that should not be discouraged.

It is worth noting, too, that some H/L clients realize during treatment that certain internalized cultural values may no longer match their personal values. This may be particularly relevant for clients who view these internalized values as informing or intersecting with their OCD symptoms, such as values of religiosity/spirituality and symptoms of religious scrupulosity. Addressing OCD symptomatology may empower individuals to further consider what these value domains mean to them and allow them to make informed decisions about how they would like to include these values in their lives going forward. Clinicians should allow space to process these conflicts in terms of cultural and personal values and let the client determine which values are best serving them and which values they no longer desire to pursue.

The heterogenous nature of OCD and H/L cultures requires clinicians to be mindful of this intersectionality and make collaborative and informed decisions when treating individuals of H/L backgrounds. Psychotherapeutic interventions, including ERP, are not fundamentally changed to account for client's unique cultural background, however, considerations must be made to fit ERP to the individual receiving care. Various aspects of H/L cultures, including religiosity, sex and gender norms, and

family systems, must be accounted to effectively deliver ERP to address the underlying psychopathology.

Conclusion

Awareness of culture is crucial for clinicians working with clients of H/L backgrounds diagnosed with OCD. Literature specific to the prevalence, presentation, and treatment of OCD among H/L individuals is currently limited, and widescale systemic barriers limit accessibility to adequate assessment and intervention. Even when presenting for care, some OCD presentations (e.g., taboo themes) may be misdiagnosed. Skilled clinicians should consider client- and family-reported cultural norms to aid in culturally tailored assessment, conceptualization, and treatment. It is imperative that wide-scale efforts to increase representation of H/L populations are made and systemic barriers to treatment for individuals of H/L backgrounds are addressed. In the absence of these actions, existing health disparities will persist.

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Online resources. LATINO study website: www.latinostudy.org

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