


# Illness perception, help-seeking attitudes, and knowledge related to obsessive–compulsive disorder across different ethnic groups: a community survey

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Received: 25 June 2015 / Accepted: 13 October 2015 / Published online: 24 October 2015  
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## Abstract

**Purpose** Despite similar prevalence rates across ethnicities, ethnic minorities with obsessive–compulsive disorder (OCD) are under-represented in research and clinical settings. The reasons for this disproportion have been sparsely studied. We explored potential differences in illness perception, help-seeking attitudes, illness knowledge, and causal attributions that could help explain the lower uptake of treatment for OCD amongst ethnic minorities.

**Methods** Two-hundred and ninety-three parents (139 White British, 61 Black African, 46 Black Caribbean, and 47 Indian) were recruited from the general population in South-East London, UK. Using a text vignette methodology, participants completed a survey including questions on illness perception, help-seeking attitudes, OCD knowledge, and causal attributions.

**Results** The groups did not differ in socio-demographic characteristics and family history of OCD. White British

parents perceived that the OCD difficulties would have more negative impact on their children and that treatment would be more helpful, compared to the ethnic minorities; the largest differences were observed between White British and Indian parents. Ethnic minorities were more prone to say that would seek help from their religious communities. Black African parents were more in favor of not seeking help for the described difficulties and, in general, perceived more treatment barriers. White British parents seemed to be better informed about OCD than ethnic minority parents.

**Conclusions** The results offer some plausible explanations for the large inequalities in access to services amongst ethnic minorities with OCD. Clinicians and policy-makers need to be aware of these socio-cultural factors when designing strategies to encourage help-seeking behaviors in these populations.

**Keywords** Obsessive–compulsive disorder · Ethnic minorities · Health disparities · Parental beliefs · Help-seeking

**Electronic supplementary material** The online version of this article (doi:10.1007/s00127-015-1144-9) contains supplementary material, which is available to authorized users.

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## Introduction

Obsessive–compulsive disorder (OCD) has similar prevalence rates across ethnic groups [1–3]. However, individuals from ethnic minorities are under-represented in both research and clinical samples, despite evidence suggesting that treatment for OCD is as effective in these groups as it is in the White majority group [4, 5]. Williams et al. [6] reviewed all randomized controlled trials of OCD published in North America from 1995 to 2008 and found that 91.5 % of participants were White. Similarly, the DSM-IV field trial, which included patients from five top OCD

specialty clinics in American urban sites, only included 5.4 % of patients from ethnic minorities [7]. More recently, similar ethnic disparities have been reported in an intensive residential treatment service in the US [8]. In the UK, Fernández de la Cruz et al. [9] looked at the ethnic distribution of 1528 OCD patients seen in secondary and tertiary clinical services in South-East London and compared it to that of the general population in the catchment area using Census data. The number of new service users with OCD per 100,000 inhabitants year was 57 % lower in the ethnic minority group as compared to the White group. This pattern was particularly pronounced for patients from Black (−71.9 %) and Mixed (−72.0 %) backgrounds.

The reasons why a big proportion of ethnic minority groups are not accessing treatment for OCD have been sparsely studied. Williams and colleagues [6] emphasized “practical” reasons such as financial barriers, language barriers, and proximity to specialty clinics, as well as cultural beliefs about the best approaches to mental illness. Interestingly, an examination of the barriers to treatment among African Americans with OCD [10] revealed unique barriers such as not knowing where to find help and concerns about discrimination. Additionally, these participants identified other variables such as the cost of treatment, stigma, fears of therapy, believing that the clinician will be unable to help, feeling no need for treatment, and treatment logistics [10]. Mistrust of the medical system has also been identified as another major barrier to people from ethnic minorities receiving mental health care [11–14].

Differences in perception of symptoms may also play a role. The ways in which people perceive illness or health threats form a central part of Leventhal’s self-regulatory model [15], which was developed to explain variations in illness-related behavior. According to this model, illness perceptions have five distinct components: (1) *identity*—the label the person uses to describe the illness together with the symptoms they view as being part of it; (2) *cause*—the person’s beliefs about the cause(s) of their illness; (3) *timeline*—the person’s beliefs about the duration and time course of their illness (i.e., acute, chronic, or cyclic); (4) *consequences*—the person’s beliefs about the effects and outcome of the illness; and (5) *perceived controllability*—the person’s beliefs about the extent to which their condition is amenable to cure or control by themselves and the health care team. Considerable research on the illness perceptions of people with a wide range of physical and mental health problems have shown that how patients perceive their illness has a significant impact on their illness coping strategies, adherence, and outcome [16, 17].

Hunt et al. [18] compared beliefs about mental illness and treatment preferences between African Americans, Hispanics, Asian Americans, Native Americans, and White Americans with anxiety disorders. Differences were found

only between Hispanics and Native Americans, and these were small in magnitude. Therefore, the authors concluded that differences in illness beliefs and treatment preferences may not fully explain the large, persistent ethnic disparities in mental health care and that other crucial barriers to quality care exist [18]. By contrast, other research conducted in the UK revealed different illness perceptions of depression between Black African and White British women, and it was suggested that illness perceptions could help explain the lower detection rates of depression in ethnic minority groups [19].

Coles et al. [20] pointed out poor mental health literacy as another potential impediment to seeking treatment for OCD. In a study exploring the attitudes of 201 African Americans regarding psychotherapy [21], participants reported insufficient knowledge of the signs and symptoms of mental health problems and that they found it difficult to discern when a condition had reached a stage requiring professional services. Additionally, lack of information led several participants to consult churches for resources and referrals.

Even though these studies may help understand the reasons for the disproportionately low rates of ethnic minorities in mental health services for OCD, few of these investigations have been conducted in non-American contexts, impeding cross-cultural generalizations to other minority groups that may not be prevalent in the US. Also, it is important to note that barriers to treatment may be different depending on the context. For example, financial reasons may not be as significant in England, where a National Health Service exists. Building on our previous study on the ethnic inequalities in the use of secondary and tertiary mental health services amongst patients with OCD in South-East London [9], the aim of this study was to shed new light on the reasons for these inequalities. Specifically, we explored illness perceptions, help-seeking attitudes, knowledge about the disorder, and causal attributions in individuals from four different ethnic groups recruited from the general community in South-East London.

## Method

### Participants

The four London boroughs of Southwark, Lambeth, Croydon, and Lewisham, which constitute the catchment area of the South London and Maudsley (SLaM) NHS Foundation Trust, were the base from where the subjects were recruited. Potential participants from the general population were approached in local libraries, children’s centers, primary schools, religious centers, leisure centers, and sport and cultural activities, in an attempt to recruit a representative slice of the catchment area’s population.

They were given information and consent was obtained prior to participation. Participants were then asked to fill out a survey which took around 10 min to complete. Inclusion criteria were: (a) self-identifies as belonging to one of the following ethnic groups: White British, Black African, Black Caribbean, or Indian, as these are the four most prevalent ethnic groups in the SLaM catchment area (after excluding the ‘other’ categories as they are too ambiguous) [22] and (b) has children under 18 years of age of their own. A total of 397 individuals agreed to participate, leading to a final sample of 293 parents (the reasons for exclusion are described in Fig. 1). The final sample included 139 White British, 61 Black African, 46 Black Caribbean, and 47 Indian parents. Table S1 (Supplemental Material) shows the ethnic composition of the recruitment area, according to the London 2011 Census [22], and the comparison with the ethnic composition of the study sample. Ethnic minorities (especially Indians) were over-sampled to ensure sufficient statistical power to study the smaller population subgroups. The study was reviewed and approved by the King’s College Research Ethics Committee (PNM/12/13-71).

## Procedure

Participants were reassured that the survey was anonymous and that they were identified by numbers only. The survey included a short vignette written by the authors representing a hypothetical case of a 12-year-old girl suffering from OCD symptoms (see vignette in Supplemental Material). The vignette methodology has been previously used in

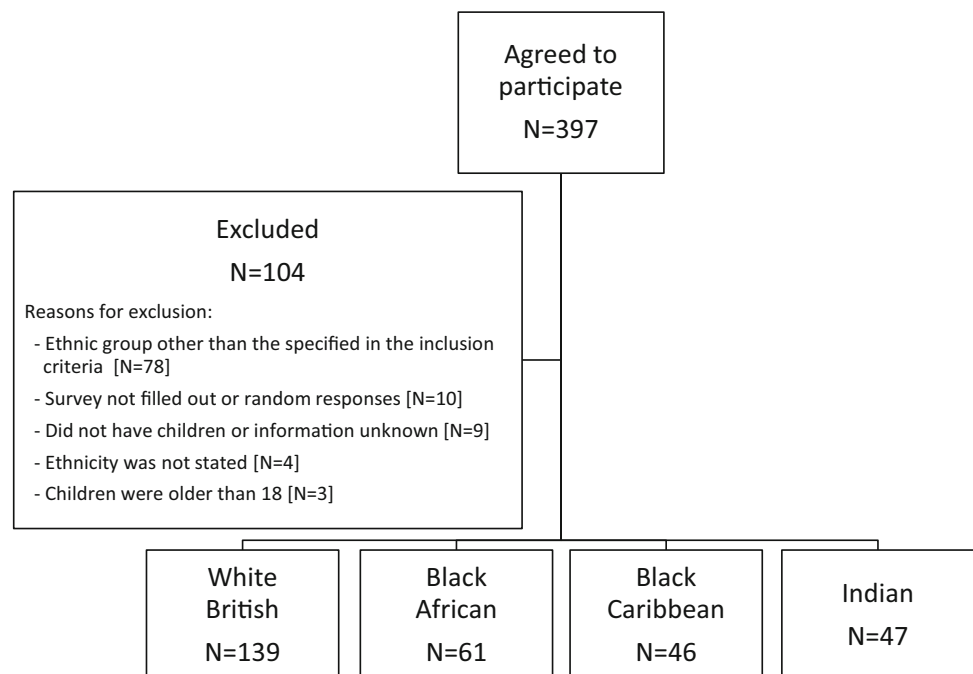
similar studies [19, 23] and found to be very helpful in obtaining responses which resemble real-life situations. Participants were asked to read the vignette and imagine that their child had similar difficulties. They were then asked to complete a series of questions on illness perceptions, help-seeking attitudes, general knowledge of the disorder, and its possible causes. We reasoned that participants would be more willing to freely disclose their views if the questions referred to third persons (i.e., their children) rather than themselves. Socio-demographic information was collected, including self-identified ethnic group, gender, age, number of children, and a number of socio-economic indicators (e.g., level of education, employment status, salary). There was no financial or in-kind compensation for study participants.

## Measures

### *Illness perception*

The Brief Illness Perception Questionnaire (BIPQ) was used to assess the perception that parents had of OCD after reading the vignette. The BIPQ is a short version of the revised version of the Illness Perception Questionnaire (IPQ-R) [24] and consists of nine items: eight about different dimensions of the illness and one open-text item about perceived causes [25]. For the purposes of this study, only the first eight items were used. Items were reworded to refer to a hypothetical case (as the illness had not to be necessarily present) and to refer to a third person, in this case, the respondent’s child (e.g., the item “How much

**Fig. 1** Flow chart displaying the number of participants that agreed to participate in the study, reasons for exclusion, and the final number of individuals in each ethnic group



your illness affects your life?” was reworded to “How much do you think these difficulties would affect your child’s life?”). The modified BIPQ can be found in the Supplemental Material.

#### *Help-seeking attitudes*

Parents were asked, on a four-point Likert scale ranging from *Completely agree* to *Completely disagree*, to what extent they would seek help from different agents, namely an elder, a friend, or a relative; their religious or spiritual advisor or their religious community; a doctor (e.g., their GP or a mental health professional); or whether they would not seek help at all if their child presented with problems similar to the ones described in the vignette. They were also asked about reasons why people may choose not to see a health professional.

#### *Knowledge about OCD*

This part of the questionnaire included five questions enquiring about: (1) the group of mental disorders in which OCD is placed (OCD was considered to be an anxiety disorder because the survey was designed before the publication of the DSM-5 [26]); (2) its prevalence in the population; (3) the primary symptoms of the disorder; (4) the most effective treatments for OCD; and (5) its relation to level of ability. Four response options were provided for each question and participants were asked to select only one of them.

#### *Causal attributions*

A list of 11 proposed causes of OCD was presented. The list was based on the Beliefs About the Causes of Child Problems (BAC)—Parent Version questionnaire [27] and included biopsychosocial causes (physical causes, personality or emotional struggles, how you get along with others, trauma, and family or parenting issues), sociological causes (the child’s friends, the English culture, discrimination or prejudice, and economic problems), and spiritual/nature disharmony causes (spiritual, cosmic, or religious reasons, and imbalance or disharmony with nature or natural elements). Participants had to rate to what extent they thought each one of these causes could lead to OCD on a four-point Likert scale (from *Completely agree* to *Completely disagree*).

#### **Data analysis**

Continuous data were compared using one-way analysis of variance (ANOVA). Ordinal data were compared using Kruskal–Wallis tests, followed by post hoc Mann–Whitney tests for comparisons between pairs of groups. Categorical data were compared using Chi-square tests. The

categories *Completely agree* and *Moderately agree* in the four-point Likert scales, as well as the categories *Completely disagree* and *Moderately disagree*, were collapsed in two single categories (*Agree* and *Disagree*, respectively), in order to simplify the presentation of the data. Significance level was set at  $p < 0.01$  to control for possible type I errors due to multiple comparisons. All tests were two-tailed. Because of missing data, sample sizes may differ across analyses. Data were analyzed using IBM SPSS Statistics, version 22.

## **Results**

### **Socio-economic variables**

The total sample was mainly formed by women (84.6 %), was an average age of 36.9 years (SD = 6.5, range = 23–58), had an average of 1.9 children (SD = 1.0, range = 1–8), was highly educated (72.2 % had at least a university degree and only 1.8 % did not have formal qualifications), and was mainly employed (61.0 %).

There were no statistically significant differences between the different ethnic groups in age, gender, number of children, education, employment status, salary, receipt of benefits, and family history of OCD. As expected, the percentage of people born in the UK was higher among White British parents ( $\chi^2 = 144.174$ ,  $p < 0.001$ ). Details on the socio-economic variables can be found in Table S2 (Supplemental Material).

### **Illness perception**

There were significant differences between ethnic groups in the *Illness symptom identity*, *Consequences of illness*, and *Treatment Control* items of the BIPQ (all  $p$ 's  $\leq 0.002$ ). Post hoc comparisons showed that the responses to these three items were significantly higher in White British as compared to Indian parents, meaning that White British perceived that their child would experience more OCD symptoms due to the illness, that the OCD difficulties described in the vignette would affect their child’s life more, and that the treatment would be more helpful. White British also showed significantly higher scores than Black Caribbean parents in *Treatment control*, and higher scores than the Black African group in *Consequences of the illness* and *Illness symptom identity* (Table 1).

### **Help-seeking attitudes**

A large majority of responders agreed that they would seek help from a doctor (95.2 %), or from an elder, a friend, or a relative (78.2 %) if their child were presenting with the

**Table 1** Results from the Brief Illness Perception Questionnaire (BIPQ) for each ethnic group

Brief Illness Perceptions Questionnaire scales <sup>a</sup>	White British (N = 139)		Black African (N = 61)		Black Caribbean (N = 46)		Indian (N = 47)		Kruskal–Wallis, $\chi^2$ adjusted for ties
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Consequences of illness	8.80 <sup>b</sup>	1.51	6.93 <sup>c</sup>	3.20	7.83 <sup>b,c</sup>	2.36	7.21 <sup>c</sup>	2.88	20.838*
Timeline	6.68	2.91	6.38	2.91	5.93	2.26	5.87	3.08	5.001
Personal control	3.51	2.72	4.91	3.17	4.37	3.09	4.39	2.80	9.760
Treatment control	8.11 <sup>b</sup>	2.12	7.34 <sup>b,c</sup>	2.94	6.95 <sup>c</sup>	2.66	6.39 <sup>c</sup>	3.09	14.324*
Illness symptom identity	7.16 <sup>b</sup>	1.77	5.21 <sup>c,d</sup>	2.83	6.54 <sup>b,c</sup>	2.45	4.98 <sup>d</sup>	2.51	38.036*
Illness concern	9.20	1.32	8.05	2.82	8.93	1.73	8.15	2.93	6.635
Comprehension	6.18	2.55	6.34	3.24	6.11	2.76	6.64	2.61	1.665
Emotional upset	8.82	1.37	8.26	2.39	8.46	1.70	7.83	2.24	8.151

\*  $p < 0.01$ ; superscripts indicate significant differences ( $p < 0.01$ ) between the individual groups after pairwise Mann–Whitney  $U$  tests performed when the omnibus Kruskal–Wallis test was significant

<sup>a</sup> Items range from 0 to 10 (*Consequences of illness*: 0 = No effect at all, 10 = Severely affects his/her life; *Timeline*: 0 = A very short time, 10 = Forever; *Personal control*: 0 = Absolutely no control, 10 = Extreme amount of control; *Treatment control*: 0 = Not at all, 10 = Extremely helpful; *Illness symptom identity*: 0 = No symptoms at all, 10 = Many severe symptoms; *Illness concern*: 0 = Not at all concerned, 10 = Extremely concerned; *Comprehension*: 0 = Don't understand at all, 10 = Understand very clearly; *Emotional upset*: 0 = Not at all affected emotionally, 10 = Extremely affected emotionally)

symptoms described in the vignette, with no significant differences between ethnic groups (Table 2). However, Black Africans were significantly more likely to agree with seeking help from their religious community (59.3 %), as opposed to only 11.8 % of White British parents. Black Africans were also the group less prone to request attention of any kind, with 31.3 % of the parents saying that they would not seek help for those difficulties. This percentage was significantly different from that from the White British (4.7 %) and the Indian (7.3 %), but not from the percentage of the Black Caribbean parents (12.8 %).

Parents were also asked about the perceived barriers that could lead them to not seek help from a doctor (Table 2). Overall, Black African parents perceived more barriers, as shown by higher percentages of agreement in most of the suggested options. All groups agreed that the main barrier for not seeking help from a doctor would be that they may disagree with them on the treatment, with no significant differences between groups.

### Knowledge about OCD

Overall, White British parents were the group with better knowledge about OCD. Most parents identified OCD as a type of anxiety disorder. However, the percentage of right answers differed by ethnic group ( $\chi^2 = 30.592$ ,  $p < 0.001$ ), ranging from 64.3 % (Indian) to 94.8 % (White British). Between-group comparisons showed that, regarding this question, the only significant differences were between White British and both Black African and Indian parents (Fig. 2a). There were no significant

differences between ethnic groups in their knowledge of the prevalence of OCD. Only between 32 and 42 % of the respondents chose the right answer (“around 1–2 % of the population”) and, interestingly, the answers reflected that between 36.7 and 53.0 % considered OCD more prevalent than it actually is (Fig. 2b). The question about the primary symptom of OCD was also answered correctly by most parents, although the ethnic minority parents showed a higher percentage of incorrect answers, as compared with the White British ( $\chi^2 = 30.199$ ,  $p < 0.001$ ; Fig. 2c). When parents were asked about the treatments they thought were most effective to treat OCD, the responses were more mixed. There were significant differences between the four groups ( $\chi^2 = 27.277$ ,  $p = 0.001$ ), which were driven by the differences between the White British and both the Black African and the Indian parents. White British parents were more likely to select cognitive-behavior therapy as the most effective treatment for young people with OCD, and less likely to select the use of medication only, while Black African and Indian parents were more likely to select family therapy (Fig. 2d). Differences between groups were also visible in the last question ( $\chi^2 = 25.995$ ,  $p = 0.002$ ), where the Black African and Indian parents, were more prone to relate OCD to the level of ability of the child, as compared to the White group (Fig. 2e).

### Causal attributions

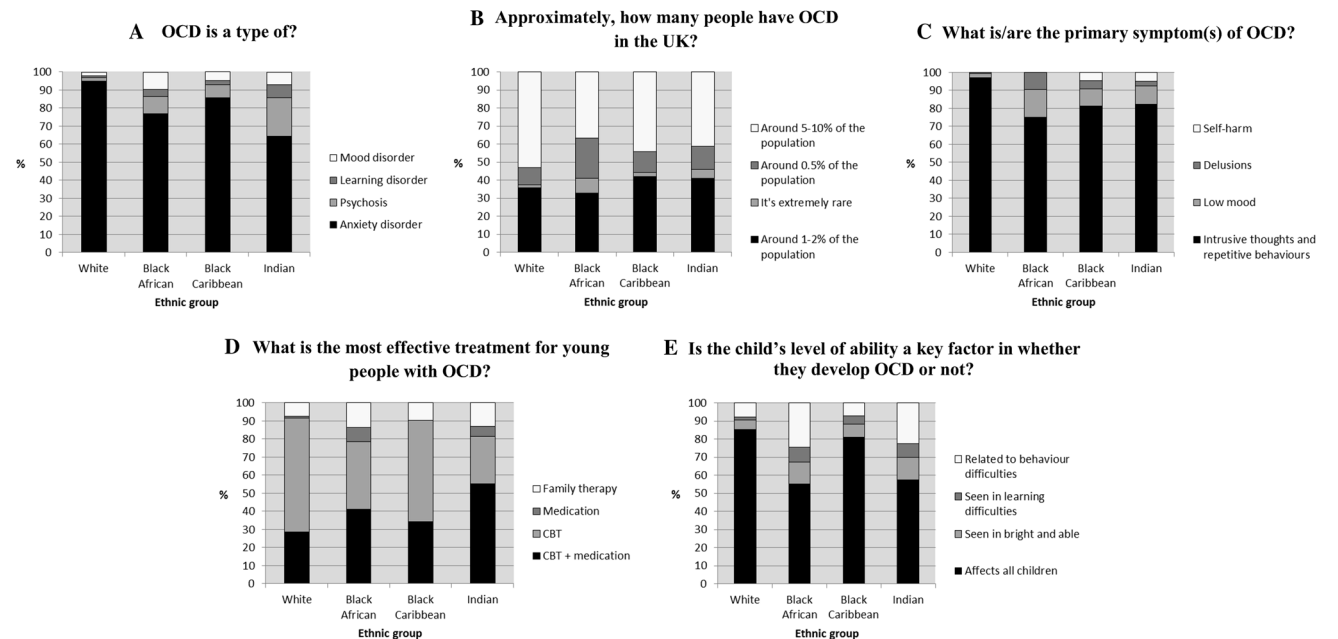
Regarding the perceived causes of OCD, both White British and Black Caribbean parents selected the child's personality or emotional struggles, a trauma that a person may

**Table 2** Help-seeking behaviors and barriers for not seeking help from a doctor

	White British (N = 139)		Black African (N = 61)		Black Caribbean (N = 46)		Indian (N = 47)		$\chi^2$
	n	%	n	%	n	%	n	%	
<b>Help-seeking behaviors<sup>a</sup></b>									
I would seek help from an elder, a friend or a relative	107	77.5	45	75.0	38	82.6	39	84.8	2.042
I would seek help from my religious community	16	11.8 <sup>b</sup>	35	59.3 <sup>c</sup>	15	33.3 <sup>d</sup>	18	38.3 <sup>c,d</sup>	48.079*
I would seek help from a doctor (e.g., GP or mental health professional)	<b>137</b>	<b>98.6</b>	<b>57</b>	<b>98.3</b>	<b>43</b>	<b>93.5</b>	<b>42</b>	<b>91.3</b>	7.289
I would not seek help for these difficulties	6	4.7 <sup>b</sup>	15	31.3 <sup>c</sup>	5	12.8 <sup>b,c</sup>	3	7.3 <sup>b</sup>	25.520*
<b>Barriers for not seeking help from a doctor<sup>a</sup></b>									
These difficulties do not require their help/advice and/or they would go away by themselves	14	10.3	13	22.4	<b>9</b>	<b>20.0</b>	4	8.7	7.366
I may not agree with the treatment (e.g., medication)	<b>23</b>	<b>17.0</b>	<b>19</b>	<b>32.2</b>	<b>14</b>	<b>31.8</b>	<b>7</b>	<b>15.2</b>	9.162
I had (or someone I know had) bad experiences	<b>16</b>	<b>11.8</b>	10	17.5	5	11.6	3	6.5	2.966
Financial reasons (e.g., transport expenses)	7	5.1	8	13.8	<b>6</b>	<b>14.0</b>	2	4.4	6.861
I would not like me or my child to be stigmatized	<b>17</b>	<b>12.5</b>	<b>14</b>	<b>24.1</b>	5	11.4	<b>6</b>	<b>13.0</b>	5.109
I would not like them to discriminate or judge me or my child due to our ethnic or cultural background	4	3.0 <sup>b</sup>	<b>15</b>	<b>25.4<sup>c</sup></b>	4	9.1 <sup>b,c</sup>	<b>4</b>	<b>8.9<sup>b,c</sup></b>	24.046*
Religious reasons	2	1.5 <sup>b</sup>	7	11.9 <sup>c,d</sup>	5	11.4 <sup>c,d</sup>	2	4.4 <sup>b,d</sup>	11.391*

\*  $p < 0.01$ ; superscripts indicate significant differences ( $p < 0.01$ ) between the individual groups after pairwise Mann–Whitney  $U$  tests performed when the omnibus Kruskal–Wallis test was significant

<sup>a</sup> Figures reflect the individuals who replied *Completely agree* or *Moderately agree* to each one of the statements. The main source of help-seeking and the three top barriers for each ethnic group are highlighted in bold



**Fig. 2** Knowledge of OCD in the different ethnic groups

have experienced, and family or parenting issues as the three most probable causes. The main causes identified by Black African and Indian parents were slightly different.

Black Africans identified physical causes as another main cause (instead of family or parenting issues), while Indians identified the child's friends as another main cause (instead

**Table 3** Views about causes of OCD in the different ethnic groups

	White British (N = 139)		Black African (N = 61)		Black Caribbean (N = 46)		Indian (N = 47)		$\chi^2$
	n	%	n	%	n	%	n	%	
To what extent you agree in that OCD is due to... <sup>a</sup>									
Physical causes	71	53.8	<b>37</b>	<b>66.1</b>	27	64.3	31	70.5	5.295
Personality or emotional struggles	<b>127</b>	<b>94.8<sup>b</sup></b>	<b>37</b>	<b>67.3<sup>c</sup></b>	<b>38</b>	<b>86.4<sup>b,c</sup></b>	<b>37</b>	<b>86.0<sup>b,c</sup></b>	25.428*
How you get along with others	66	48.2	29	52.7	21	48.8	31	72.1	7.870
A trauma that a person may have experienced	<b>129</b>	<b>94.2<sup>b</sup></b>	<b>37</b>	<b>67.3<sup>c</sup></b>	<b>37</b>	<b>84.1<sup>b,c</sup></b>	38	84.4 <sup>b,c</sup>	23.481*
Family or parenting issues	<b>106</b>	<b>78.5<sup>b</sup></b>	29	55.8 <sup>c,d</sup>	<b>33</b>	<b>75.0<sup>b,d</sup></b>	<b>39</b>	<b>88.6<sup>b</sup></b>	15.615*
The child's friends	102	74.5 <sup>b</sup>	28	51.9 <sup>c</sup>	26	60.5 <sup>b,c</sup>	<b>42</b>	<b>95.5<sup>d</sup></b>	25.617*
The English culture	34	24.8 <sup>b</sup>	23	43.4 <sup>b,c</sup>	18	41.9 <sup>b,c</sup>	29	65.9 <sup>c</sup>	25.676*
Discrimination or prejudice	52	38.0	23	42.6	16	37.2	25	58.1	5.934
Economic problems	33	24.3 <sup>b</sup>	22	40.7 <sup>b,c</sup>	12	27.9 <sup>b,c</sup>	21	48.8 <sup>c</sup>	11.589*
Spiritual, cosmic, or religious reasons	9	6.6	7	13.5	9	21.4	8	18.6	9.089
Imbalance or disharmony with nature/natural elements	16	11.9 <sup>b</sup>	16	31.4 <sup>c,d</sup>	11	26.2 <sup>b,d</sup>	12	28.6 <sup>c,d</sup>	12.260*

\*  $p < 0.01$ ; superscripts indicate significant differences ( $p < 0.01$ ) between the individual groups after pairwise Mann–Whitney  $U$  tests performed when the omnibus Kruskal–Wallis test was significant

<sup>a</sup> Figures reflect the individuals who replied *Completely agree* or *Moderately agree* to each one of the statements. The three top causes for each ethnic group are highlighted in bold

of traumas that a person may have experienced). However, there were significant differences between groups in the importance given to each one of the causes (see Table 3 for details).

## Discussion

### Illness perception

We found significant differences between groups in three dimensions of the BIPQ. Compared to White British parents, parents from ethnic minority groups—especially Indian participants—thought that the symptoms would not negatively affect their children's life as much, were more uncertain about how helpful the treatment would be, and thought that their children would not experience many symptoms if they were suffering from OCD. The fact that Indian parents were less likely to see it as a problem may reflect cultural attitudes to child rearing. It may also reflect a lack of knowledge about the illness. Interestingly, these same three dimensions also differed between White British and Black African women in an English study looking at how these minority groups perceived depression symptoms [19]. The authors concluded that these differences could help explain general practitioners' lower detection rates of depressive problems in Black African women. For example, certain patterns of illness perceptions could lead to mental health problems being "normalized" resulting in a lower probability of the illness being detected [19].

However, differences in illness perception between ethnic groups may not necessarily translate into lower referral rates [28], which highlights the importance of distinguishing between being referred to services and the subsequent use of services.

### Help-seeking attitudes

Black African parents were more likely to state that they would not seek help for the described OCD difficulties, followed by Black Caribbeans. This could help explain our previous finding showing that the new service users with OCD per 100,000 inhabitants year was about 72 % lower in Black individuals as compared to Whites in the same catchment area [9]. Nonetheless, the great majority of parents, independently of their ethnic group, agreed that, if they had to seek help, they would get it from a doctor. When looking at sources of help, a higher percentage of parents from ethnic minorities expressed that they also would seek help from their religious community (especially the Black African group), as compared to the White British parents. This is in accordance with previous literature showing that ethnic minorities tend to rely on informal support through friends, family, and spiritual or religious leaders more than their White counterparts [29]. It may also reflect that these symptoms are not being seen as a medical condition, but perhaps a characterological trait.

The barrier more frequently endorsed for all ethnic groups was related to a potential disagreement with the treatment (e.g., medication). This has particular specific

connotations for medicating children, which again may be very culturally influenced attitude and phenomenon. Previous studies have suggested that different ethnic groups may be more prone to receive specific interventions. In a sample of 577 US adults (50.3 % Caucasian; 49.7 % African Americans), Coles et al. [20] found that Whites were more likely to recommend consulting a primary care physician than African Americans, and that African Americans were more likely to recommend seeing a psychiatrist than Whites. However, other studies have shown that African Americans generally report less willingness to take psychiatric medication and have a preference for counseling, compared to Whites [30, 31]. Unfortunately, our study did not explore treatment preferences across ethnicities.

While Black Africans seemed to endorse more frequently the proposed barriers to seek help from a doctor, only two of the seven barriers showed statistical differences in their rates of endorsement from different ethnic groups. Black African parents were more likely than White British parents to agree in that they would not like doctors to discriminate or judge them due to their ethnic or cultural background. Also, Black African and Black Caribbean parents were more likely than the White British parents to mention religious reasons as a treatment barrier. In spite of this, endorsement of the suggested barriers was generally low for all ethnic groups. Interestingly, Yeh et al. [32] found that, in a sample of 1715 youth aged 6–17, African Americans, Asian/Pacific Islander Americans, and Latinos all endorsed a lower number of barriers than did the non-Hispanic Whites and that barrier endorsement was unrelated to unmet need in that sample.

### Knowledge about OCD

White British parents were better informed about OCD, while Black African and Indian parents seemed to be the ones with less knowledge. It has been suggested that poor mental health literacy might be one of the earliest impediments to help-seeking behavior [33]. As stated by Coles and colleagues [20], better information regarding the public's knowledge of OCD and its treatment would be helpful in designing future, more effective educational interventions.

### Causal attributions

It has also been shown that differential beliefs about the causes of mental health problems may result in help-seeking patterns that do not involve professional mental health services [13]. In a study examining ethnic patterns

of parental beliefs about etiological explanations for youth problems in a sample of 1338 parents, Yeh et al. [27] showed that ethnic minority parents were less likely to endorse biopsychosocial beliefs, with few ethnic differences for sociological or spiritual/nature disharmony etiologies. In our study, Black African parents were less likely to attribute OCD to biopsychosocial causes than the White British parents (three of the five biopsychosocial causes presented with significant differences), which may have implications for help-seeking, utilization, and effectiveness of biopsychosocially oriented mental health services [27, 34].

### Implications and future directions

The results of the present investigation suggested a number of reasons that may partially explain the differences in the access to treatment for OCD among ethnic minority groups. These findings need to be taken into account by clinicians and policy-makers in order to ensure sensitivity to differing cultural values about mental health throughout minority groups but also to encourage symptom recognition and help-seeking behaviors by these populations.

Our outcomes highlight that ethnic minorities vary in their attitudes and perceptions, and service planning needs to take this into account. For example, in most studies, individuals from Black background are grouped together, with a few notable exceptions (e.g., [2]). However, our study identified several discrepancies between Black African and Black Caribbean parents. Overall, Black Caribbean parents were more similar to the majority White British group, whereas Black African parents endorsed more barriers to access treatment. This would emphasize the need for focusing specifically on the particular barriers that each ethnic community identifies when developing interventions and strategies to improve access to mental health services for these groups.

Strategies for engaging the ethnic minority groups may include the formation of connections with community organizations, churches, and local leadership to raise awareness about OCD, its devastating consequences, and the availability of evidence-based treatments. Additionally, qualitative studies (e.g., focus groups) can be helpful to achieve a deeper understanding of possible barriers to help-seeking and inform strategies to encourage ethnic minority groups to seek professional help for OCD. Involvement in school-based services has also been suggested as a relevant source to facilitate specialist outpatient mental health service use for youths [35]. Also, it has been suggested that adapting current interventions to suit the needs of ethnic minorities could influence the way individuals perceive or respond to interventions [36].



## Limitations

This study includes several limitations. First, participants were mainly recruited from local libraries, children's centers, and other local cultural activities, which may have biased the sample towards those people more involved in the community and/or more highly educated. Second, people that agreed to take part in the study may have a more positive attitude towards health issues, compared to those who declined to participate. Third, the investigators who recruited the participants were White Europeans (non-British), which may have been an issue accessing ethnic minority groups. Fourth, nearly 85 % of the sample was formed by mothers and we cannot rule out that fathers have different views about health-related issues. All these aspects may limit the generalizability of the results. Generalization of the findings to other countries and cultures should be done cautiously. Fifth, a higher percentage of ethnic minority parents were born outside the UK, compared to the White British. Unfortunately, the sample size did not allow comparisons between parents born in- and outside the country. Finally, because our study did not explore treatment preferences across ethnic groups, disagreement with treatment—a frequently endorsed barrier—could not be explored in further detail.

## Conclusion

Significant differences in illness perceptions, help-seeking attitudes, knowledge related to OCD, and causal attributions exist across ethnic groups in South-East London. These differences may help explain the large inequalities in access to services amongst OCD patients from ethnic minorities. Clinicians and policy-makers should be aware of these socio-cultural factors when designing strategies to encourage help-seeking behaviors in these populations.

**Acknowledgments** We wish to thank all the parents that kindly participated in our study as well as the following gatekeepers for their invaluable help during the recruitment process: Lewisham Library; Forest Hill Library; Clapham Library; Deptford Library; Brixton Central Library; South Lambeth Library; Carnegie Library; Minet Library; Streatham Library; Durning Library; Tooting Library; Upper Norwood Library; Crofton Park Community Library Service; Ivydale Primary School; St. James The Great Primary School; Children's Playroom at Peckham Rye; Tunstall Children's Centre; Fegans Child and Family Care, St. Stephen's Church; Stay and Play Group, St. Paul's Church; Family Action Newpin; Peckham Pulse Healthy Living Centre; Brixton Recreation Centre; Community Engagement Division, Housing, and Community Services at Southwark Council; IoPPN Café Dinner employees; Alison Henry, Therapist at 104 Harley Street; Abdul Wuraola, Performance Director and Head Coach at Dulwich Table Tennis Club; and Sunil Chopra, from the Hindu Community Centre in Southwark.

## Compliance with ethical standards

**Conflict of interest** None.

**Ethical standards** The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

**Funding** The authors acknowledge financial support from the South London and Maudsley Charitable Funds (Grant Number 2012/604). Mr. Pablo Vidal-Ribas was supported by a fellowship from the Alicia Koplowitz Foundation. Dr. Stephani L. Hatch receives salary support from the National Institute for Health Research (NIHR) Mental Health Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health.

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