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Preliminary Study of OCD and Health Disparities at the U.S.-Mexico Border

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Abstract

The widespread and devastating nature of obsessive compulsive disorder (OCD) sharply contrasts with the paucity of research involving Mexican Americans and Mexicans who suffer from this condition. This mixed-methods preliminary study was intended to provide initial data and to pilot the procedures for a larger investigation of the cultural identification, symptomatology, health concerns, coping mechanisms, and quality of life of Mexican Americans and Mexicans with OCD living in the U.S.-Mexico border region of El Paso, Texas and Ciudad Juarez, Mexico. For the sample of six participants, whose symptoms ranged from moderate to extreme, OCD was associated with marked impairment in quality of life, particularly in terms of social functioning, an area of central importance for many Mexican Americans and Mexicans. Areas of further study were identified, with the aim of developing culturally sensitive interventions to decrease health disparities involving OCD.

Keywords

obsessive-compulsive disorder (OCD); Hispanics; border; mixed methods

Obsessive-compulsive disorder (OCD), or *tras-tomo obsesivo compulsivo* (TOC) as it is known in Spanish-speaking countries, ranks 10th in the World Bank's and World Health Organization's leading causes of disability for persons age five and older (World Health Organization [WHO], 1999; see also Greist, 1999; Lopez & Murray, 1998; Murray & Lopez, 1996). For women in the 15 to 44 year age group, it is ranked as the fifth leading cause of disability (WHO, 1999). Yet there is a dearth of information on the relationship between culture, ethnicity, and OCD, particularly for Hispanic persons with this disorder. This descriptive study used mixed methods to provide preliminary data and to pilot the procedures for a larger investigation of the cultural identification, symptomatology, health concerns, coping mechanisms, and quality of life of persons with OCD in a population at high risk for health disparities, Mexican American and Mexican persons living in the U.S.-Mexico border region of El Paso, Texas and Ciudad Juarez, Mexico. This objective is consistent with the primary mission of the American Psychiatric Nurses Association (APNA), which is "to improve mental health care for culturally diverse individuals, families, groups and communities" (APNA, 2005, paragraph 3).

Background and Significance

OCD, Disparities, and Public Health

The most widely accepted prevalence data indicate that OCD afflicts between 2% and 3% of the world's population, making it at least twice as common as schizophrenia (Hollander, 1997; Horwath & Weissman, 2000; Karno, Golding, Sorenson, & Burnam, 1988; Weissman et

al., 1994). The hallmark symptoms of OCD include: (a) intrusive, recurrent, unwanted, and inappropriate thoughts or obsessions, such as excessive fear of germs or dirt; and (b) time-consuming rituals or compulsions, such as repeated hand washing, intended to decrease the anxiety engendered by the obsessions. Like schizophrenia, OCD is a neurobiological disorder that is associated with a similarly negative impact on quality of life (Bobes et al., 2001). However, the “treatment gap” for OCD, that is, the estimate of the true prevalence of the disorder versus those who receive treatment and care, is dramatically higher for OCD than for schizophrenia—32.2% for schizophrenia and 57.3% for OCD (Kohn, Saxena, Levav, & Saraceno, 2004).

Based on the available epidemiological research, the proposed study potentially could benefit between 30,000 to 45,000 persons suffering from OCD in Ciudad Juarez, nearly all of whom are Mexican, and 15,000 to 22,500 persons in El Paso, more than three-quarters of whom are Mexican or Mexican American (Paso del Norte Health Foundation, 2005). The potential of the data in informing care, however, extends well beyond these individuals to include families and the larger community. The National Institute of Mental Health [NIMH] (1999) estimates that OCD cost the United States \$8.4 billion in 1990, or approximately 6% of the total mental health bill of \$148 billion. Moreover, the public and personal toll exacted by OCD in the Border region is likely to be exacerbated by health conditions that one government official (Strayhorn, 1998) described as “among the worst in the U.S., so distressful at times that reports on health conditions suggest a remote country in need of medical missionaries, not a part of Texas” (p. 1).

The Border region’s health care finance system is an obvious precipitator of this crisis, with only 40% of Texans living in Border cities like El Paso having private insurance, which amounts to an “epidemic of ‘uninsurance’” (Texas Comptroller of Public Accounts, 1994, paragraph 7). Of all ethnic groups in the United States, Hispanic Americans are the least likely to have health insurance, public or private (U.S. Surgeon General, 2001). A direct result of the lack of payment sources is a shortage of skilled health providers, particularly in the area of mental health. Although 63% of Border counties were designated by the U.S. Department of Health and Human Services as Health Professional Shortage Areas (HPSA) for primary medical care—a serious situation in itself—95% of the counties, including El Paso County, were designated HPSAs for mental health care. In general, areas with a high concentration of minority inhabitants such as the Texas-Mexico Border region have “several disparities affecting mental health care. . . . (including) less access to and availability of mental health services . . . poorer quality of mental health care . . . (and) underrepresentation in mental health research” (U.S. Surgeon General, p. 6; see also the President’s New Freedom Commission on Mental Health, 2003).

Across the Border, in Ciudad Juarez and surrounding communities, the situation is perhaps even more dire, though the relevant information needs to be refrained. First, the organization of the health care system in Mexico is substantially different from that in the United States, with one of five sectors of the system essentially covering all Mexican citizens. These sectors range from the *Secretaria de Salud y Asistencia*, which provides health care for impoverished clients, to the private sector, which mainly addresses the health needs of those with private insurance. In addition, data keeping in Mexico provides much less detailed information regarding health care in general, and psychiatric-mental health care in particular, than in the United States (Medina-Mora et al., 2003; Suarez & Arizpe, 2004). Thus, the challenge is to look beyond official government assertions of 100% health coverage to the reality of psychiatric-mental health care in Ciudad Juarez. For instance, a total of just nine psychiatrists serve the entire city of two million, which includes an estimated 175,000 individuals with serious psychiatric problems (Castanon, 2005). Moreover, only three of these psychiatrists work in the public sector; the other six serve private clients (Castanon). The only public

psychiatric hospital, *Hospital Civil Libertad*, can accommodate a mere 35 clients. Thus, the reality of psychiatric treatment and care in Ciudad Juarez is drastically different than that suggested by official organizational charts and government data.

Culture, Ethnicity, and OCD

The review of the literature addressed (1) research involving OCD and broader issues related to culture, ethnicity, and/or health disparities and (2) research involving OCD and specific cultural, ethnic, and/or disparities issues related to Mexican Americans or Mexicans. Major databases were reviewed for publications in the 20 years from 1984 to the present. These databases included PubMed, CINAHL, PsycInfo, Anthropological Index Online, Sociological Abstracts, and Social Service Abstracts; databases searched from the *Universidad Autonoma de Ciudad Juarez* included Premier Search, Academic Search, MedicLatina, and *Fuente Academica*. Search terms included OCD (TOC for the Mexico literature review), separately and in combination with each of the following: culture (*cultura* in Mexico), ethnicity, race, Mexican, Mexican American, and Hispanic. The search included studies published in both English and Spanish. The inclusion criteria for the research-focused literature review included studies in which: (a) OCD/TOC was the primary focus, with an additional emphasis on issues involving culture, ethnicity, quality of life, and/or health disparities in relation to Mexican Americans and/or Mexicans; (b) study participants were adults or the study had immediate relevance for the study of adults with OCD; and (c) the study was published in English or Spanish. A total of 49 potential studies were identified, but further review revealed that none met the full criteria. Two studies, as described immediately below, came close to meeting the criteria, and several other works described later included relevant pieces of information.

Nicolini, Weissbecker, Mejia, and Sanchez De Carmona (1993) provided both a primary focus on OCD and Mexicans and some discussion of cultural issues. This study is particularly noteworthy as the first investigation of individuals with OCD in Latin America. For the modest sample of 27 mostly middle-class adults and their families, the researchers found a significant pattern of familial-genetic susceptibility for the disorder, along with a significant difference in the sex ratio of OCD patients (5 males to 22 females). This last finding contrasts with the generally accepted notion of an equal gender distribution for OCD (Jenike, 2004). The researchers contended that this difference “could be due to a cultural phenomenon in which the Mexican male tends to deny mental illness” (Nicolini et al., 1993, p. 196). Unfortunately, there was no further discussion of this finding. Comorbidity data also revealed a high rate of comorbid depression, sexual abuse, neurological damage and, contrary to more recent research (Gabbard, 2001), obsessive-compulsive personality disorder.

Karno and colleagues (1989) examined the prevalence rates for anxiety disorders in general, including OCD, among Mexican Americans and non-Hispanic Whites in Los Angeles, California. The researchers highlighted the dearth of cross-cultural research involving persons with anxiety disorders, described as striking because anxiety disorders comprise the largest, most common category of psychiatric illness, more common than other categories such as mood disorders or psychotic disorders. Additionally, the authors found that Mexican Americans born in the United States had higher rates of agoraphobia than immigrant Mexican Americans and higher rates of simple phobia than either the immigrant group or the non-Hispanic White group. Non-Hispanic Whites were reported to have higher lifetime rates of generalized anxiety disorder compared with both immigrant and U.S.-born Mexican Americans. No differences in lifetime prevalence rates were found for panic disorder, social phobia, or OCD. The findings remained unchanged when the researchers controlled for socioeconomic status, and so selective migration was postulated as an “intuitively” likely influence, that is, “a tendency for less distressed individuals to migrate from Mexico to the United States” (Karno et al., 1989, p. 206). However, the possible influence of selective

migration was not explored, nor was there a discussion of cultural influences that might have contributed to differences in symptom manifestation or methods of coping.

In Spanish-language research articles identified in the above databases, there was little attention to cultural factors. Nicolini and colleagues (1996) tested a Mexican Spanish translation of the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). The Y-BOCS, developed by Goodman and colleagues (1989b; Goodman, Price, Rasmussen, & Mazure, 1989a), is the most widely used scale to assess severity and change over time in symptoms of OCD (Sajatovic & Ramirez, 2003), although at the time of the Nicolini and colleagues (1996) study no such Spanish-language tools were available. Using 105 interviews involving 35 adult clients with OCD, and rated by three psychiatrists, the researchers concluded that the Mexican Spanish version of the Y-BOCS is a reliable and valid instrument, useful for both clinicians and researchers in adult assessment (Nicolini et al., 1996). A related study (Ulloa et al., 2004) confirmed the reliability and validity of the Spanish version of the Children Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) in Mexico. Sal y Rosas and colleagues (2002) sampled 20 adult clients with OCD in Peru, also finding that the Spanish version of the Y-BOCS “is reliable, homogeneous and valid for quantification of... obsessive-compulsive symptoms” (p. 30).

Research from Spain included articles by Martinez (2001,2002) involving a single sample of 66 individuals previously diagnosed with OCD. Similar to Nicolini and colleagues (1993), Martinez (2002) identified a higher proportion of female to male OCD clients (1.8:1), although no attempt was made to explain this result. The overall prevalence rate was consistent with other researchers (Jenike, 2004). In a second article, Martinez (2001) discussed the administration of a self-developed questionnaire designed to measure the perception of persons with OCD regarding their knowledge of the disorder, types and effectiveness of treatments, satisfaction with treatment, and symptom evolution. Although he noted significant findings related to the questionnaire, the number of subjects included in the various comparisons to support his findings involved, in some cases, less than three persons. Nor did Martinez (2002) establish the reliability or validity of his perceptions tool. Still, based on the information that he had, Martinez (2002) decried the scarcity of treatment for OCD and the negative repercussions this scarcity has had on job productivity, family life, and the overall well-being of communities. Segalas and colleagues (2002), using a Spanish population, explored the personality characteristics of 48 individuals diagnosed with OCD. The findings supported the conclusions of other researchers while at the same time making intuitive sense, in terms of the tendency of OCD sufferers to demonstrate harm avoidance and dependence (Segalas et al.). Alonso and colleagues (2001) focused on perceived parental rearing styles for 40 clients with OCD in Barcelona, finding that none of the identified rearing characteristics allowed prediction of the development of OCD symptomatology. The researchers emphasized, however, that further investigation is needed “to study, in depth, the role which social and cultural variables” play in OCD (Alonso et al., p. 94).

Quality of life for individuals with OCD has also been studied in Hispanic populations, although not directly involving Mexican Americans or Mexicans. Koran, Thienemann, and Davenport (1996) pioneered “the first description of the health-related quality of life of adults with obsessive-compulsive disorder” (p. 783). They surveyed 60 adults with OCD engaged in an outpatient pharmacological treatment trial at Stanford University Medical Center, using the Y-BOCS to gauge symptom severity and the Short Form 36 Health Survey or SF-36 (Ware, Snow, Kosinski, & Gandek, 1993) to measure quality of life. The researchers found that persons with moderate to severe OCD demonstrated both impaired social functioning and impaired instrumental role performance (Koran et al., 1996). However, only impairment of social functioning was linearly related to severity of OCD. No information was provided on the ethnicity or cultural backgrounds of the participants. In a more recent study, Bobes and colleagues (2001) used the Y-BOCS and the SF-36, as well as the WHO Short Disability

Assessment Schedule (WHO DAS-S), in examining a sample of 36 noninstitutionalized individuals with moderately severe OCD residing in Spain. Participant scores on the SF-36 were compared with similar data from a variety of other samples: a Spanish normative population; 60 U.S. OCD clients; 362 outpatients with schizophrenia; 729 depressed clients; 132 heroin-dependent individuals; and 380 persons with end-stage renal failure. The results showed that quality of life for OCD clients was exactly as poor as that of schizophrenic clients, the lowest health-related quality of life across all of the groups that were analyzed (Bobes et al., 2001). The highest level of disability for persons with OCD corresponded to social functioning (SF-36 measure) and occupational functioning (WHO DAS-S measure). Social functioning stood out as the area most affected by OCD in the Spanish sampling, compared with the U.S. sample in which it ranked fourth. The researchers suggested that cultural differences might account for this finding, “in that the social component of a Spaniard’s life tends to be more important to him” (Bobes et al., 2001, p. 244). This possibility was only mentioned, however, and other issues related to health disparities, culture, and ethnicity were not examined.

In general, the literature review emphasizes the importance of the current study, as well as the larger project for which it lays the groundwork, and suggests the application of this study to a range of mental health conditions and related treatment and care issues involving diverse cultural groups. It also highlights the specific aim of the study: to provide preliminary data and to pilot the procedures for a larger investigation of the cultural identification, symptomatology, health concerns, coping mechanisms, and quality of life of persons with OCD in a population at high risk for health disparities, Mexican Americans and Mexicans living in the U.S.-Mexico Border region of El Paso, Texas and Ciudad Juarez, Mexico.

Methods

This study employed a mixed-method approach in order to provide preliminary data and pilot the procedures for a larger study of the cultural identification, symptomatology, health concerns, coping mechanisms, and quality of life issues of Mexican Americans and Mexicans with OCD living in the Border region. The sample, instruments, procedure, limitations, and timetable are described below.

Sample

Purposive sampling was used due to the unique population of interest, adult Mexican Americans and Mexicans diagnosed with OCD in the Border region. The uniqueness is a result of two important factors: the lack of recognition of this disorder among the general population, and the characteristic shame and embarrassment that persons with OCD tend to feel about their symptoms. Unlike other neurobiological disorders such as schizophrenia, this last factor frequently leads sufferers to go to great lengths to hide their condition from others. A total of six Mexican American or Mexican adults, age 18 or over, Spanish-speaking or bilingual (English and Spanish), diagnosed with OCD, and living in the specified Border region were included in this research.

Instruments

Four tools validated for English- and Spanish-speaking persons were used:

1. The demographic tool includes basic data that in previous studies was deemed as relevant to the experience of OCD, as well as data determined to be of general importance in health surveillance by the Centers for Disease Control and Prevention (2002) and the Paso del Norte Health Foundation (2005). It also incorporates the 12-item Short Acculturation Scale for Hispanics (SASH) (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987). This scale has been shown to have adequate

psychometric properties and is available in both English and Spanish (Malgady & Constantino, 1998; Marin et al., 1987).

2. Severity of OCD was evaluated with the 10-item Y-BOCS. The Y-BOCS is both brief and easy to administer, and available in both English and Spanish. The authors of the tools reported reliability coefficients of .72 to .98; intraclass correlation has been reported as .80 (Goodman et al., 1989a). In the study of the Mexican Spanish version of the Y-BOCS, Nicolini and colleagues (1996) reported a high overall reliability (Cronbach's alpha of .85), adequate content, and face validity.
3. As no specific tool exists for measuring quality of life for persons with OCD, we chose the Short Form 36 Health Survey Version 2, or SF-36v2 (Ware et al., 1993), a widely used scale designed as a general indicator of functional health, well-being, and general health perceptions. The SF-36v2 is brief (taking approximately 10 to 15 minutes to complete) and available in English and Spanish. It includes 36 items that are organized into two summary measures (physical health and mental health) and eight multi-item subscales: physical functioning; role limitations due to physical problems; bodily pain; social functioning; general mental health; role limitations due to emotional problems; vitality; and general health perceptions. In general, the median alpha reliability for all scales, including both the English and Spanish versions, exceeds .80 (Bobes et al., 2001). The criterion validity information for all the scales suggests a significant and consistent association with the validation criteria (Durán-Arenas, Gallegos, Salinas-Escudero, Martinez-Salgado, 2004; Sajatovic & Ramirez, 2003).
4. To guide the interview, the OCD Semi-Structured Interview Guide, or OCD-SSIG (Olson, Vera, & Perez, 2005a), was developed from a preliminary study which focused on culture, ethnicity, and coping mechanisms and OCD. The categories and specific questions for the guide were formulated through an exhaustive, 3-month process of coding, comparison and re-coding of 10 in-depth interviews with a diverse sample of adults with OCD. The English version of the demographic tool was translated into Spanish by a bilingual, master's level anthropologist, who was also fluent in the nuances of Spanish language in the Border region. A bilingual graduate student in public health then completed a blind back-translation into English. The two versions were compared and revisions made.

Procedure

Participants were obtained from referral by a private clinician and self-referral through contact with the local affiliate of the National Alliance for the Mentally Ill (NAMI) and a newspaper article describing the study. Informed consent was obtained and each participant was provided a gift certificate of \$15 to a local discount or department store. Diagnostic screening included direct confirmation (participants were asked: "Have you been diagnosed with OCD by a health care provider?") and secondary screening. The secondary screening involved asking the six questions from the OCD section of the Mini International Neuropsychiatric Interview or MINI (Sheehan et al., 1998). Multiple studies have demonstrated the reliability and validity of the MINI, whether used by section or as a whole, for screening of major psychiatric disorders among both Spanish- and English-speaking persons (Amorim, Lecrubier, Weiller, Hergueta, & Sheehan, 1998; Fineberg et al., 2003; Lecrubier et al., 1997). After screening, the second author administered the four study tools in a face-to-face meeting lasting approximately 1 hour. The semi-structured interview was audiotaped for elucidation and validation of notes taken by the interviewer.

Data Analysis

For this limited pilot study, quantitative data from the four tools were analyzed using descriptive statistics. In addition, cumulative data from the SF-36 were compared with norms established for Mexico and the United States (Durán-Arenas et al., 2004; Ware et al., 1993). Qualitative data from the semistructured interviews were analyzed using the Consensual Qualitative Research approach, or CQR (Orcher, 2005). CQR specifies a series of procedures to code data across participant responses and is consistent with other frameworks for identifying themes and patterns in qualitative data (Burns & Grove, 2003; Orcher). Particularly for the larger study that will follow this pilot, this triangulated approach analysis is intended to facilitate exploration of the findings for implications regarding specific, culturally sensitive interventions most likely to be effective in Mexican Americans and Mexicans' real-life situations.

Results

The six participants included three males and three females, ranging in age from 23 to 54 (mean age = 40.5 years of age; $SD = 6.4$). All were Spanish-speaking or bilingual, although only one preferred to have the interview conducted in English. Two individuals resided permanently in El Paso and four lived in Ciudad Juarez. All identified as Hispanic, with five born in Mexico and one born in the US. Half were single and half were in committed relationships. Two persons had completed only elementary school, one had finished high school, and three had advanced beyond high school to at least some college or additional vocational training. Five earned less than \$25,000 per year and one earned slightly more than that amount. Occupational backgrounds were varied, including a forensic investigator, telephone operator, mental health worker, environmental engineer, salesperson, and homemaker. Four of the participants had a significant comorbidity, including one person with Tourette's syndrome, one with Bipolar disorder, and two persons with moderate to severe depression. Such comorbidities are common with OCD and generally not considered exclusionary in terms of research. As shown in Table 1, participants' OCD treatment and care was somewhat varied, although at the time of interview only two individuals were receiving one of the several medications shown to be effective in treating OCD. No participants, based on their descriptions, were involved in exposure response prevention therapy at the time of interview. Exposure response prevention is a type of cognitive behavioral therapy (CBT) that also has been proven effective in treating OCD (Abramowitz & Franklin, 2003; Jenike, 2004).

Symptom severity, as measured by the Y-BOCS, can range from subclinical to extreme (see Table 2 for a summary of results in this paragraph), with in-between gradients of mild, moderate, and severe. Overall, participants had a moderate or higher level of symptoms—three fell into the moderate category, two into the severe category, and one into the extreme category. Cultural identification, as measured by the SASH, demonstrated that all but one person identified as “more Hispanic than Anglo.” Even the one outlying score could be considered in the “almost fifty-fifty” range (Mindt et al., 2003). The SF-36v2 was scored using norm-based methods (50 is the mean for the general U.S. population, so scores above or below 50 are above or below the average in the general U.S. population). The overall summary physical scale component is contributed to most by the subscales of physical functioning, role-physical, and bodily pain. For the pilot sample, the summary physical scale was 52.74, slightly above the U.S. norm. However, it was substantially below the norm of 79.0 established by Durán-Arenas and colleagues (2004) for the Mexican states of Oaxaca and Sonora. In contrast, the summary mental scale component—contributed to most by the mental health, role-emotional and social functioning subscales—was 27.81 for the pilot sample, well below that of the U.S. norm and dramatically lower than the Mexican norm of 76.7. The respective subscale scores for the sample were 29.58 for social functioning, 39.03 for role-emotional, and 27.95 for mental health.

The qualitative data analysis allowed in-depth exploration of individual experiences and thus was less constrained by the small *N* value. Although the OCD-SSIG highlighted certain areas determined to be crucial based on previous research, the interview also ensured that participants could expand on these areas and/or add other information. Aside from the particular themes that emerged within the interview categories, the participants provided unique insights into their disorder, often with a metaphor. For instance, one participant explained, with OCD “I am like a car that hits a pothole and gets stuck there and when I finally get out I hit another one.” The first individual interviewed referred to his intrusive thoughts, saying, “I feel like a monster in my head.” Another observed that OCD is “like having a stone in your shoe, it bothers me and causes desperation.”

The types of symptoms described by the participants were varied, as shown in Table 3. Some individuals equally highlighted obsessions and compulsions, while others focused mostly on one symptom area. The personal meaning of these symptoms is best expressed in the participants’ actual words:

- “When I travel on an airplane, I think about opening the emergency exit doors, and I want someone to tie me down. Also, if I’m alone with children, I think about hitting them and it horrifies me, I feel like locking myself in the bathroom, I have never done anything ... I get headaches after these episodes. The more I try to avoid them, the more they come up. I don’t do the things I would like because of these thoughts.”
- “I had to kiss all the saints I found, images and everywhere, I had to go around the house in the same order, kiss them always in the same order.”
- “I started to use a lot of toilet paper to clean myself after defecating, excessive, to the point where they had to move us to another (hotel) room twice because I would clog the toilet and I would leave the bathroom full of paper, inside the toilet and all around the bathroom. I would use up all the toilet paper and the Kleenex boxes and I still did not think I was clean after going to the bathroom.”
- “I have a thing with numbers; even numbers are a major thing. I think in even numbers, words that I say, how many letters in that word, when I eat, everything has to be in even numbers and if it’s two noodles, it has to go from two to four, it cannot be three or five. I have six kids, because I didn’t want to have an odd number of kids.”

All participants emphasized issues involving relationships with others. The issues were twofold: difficulties with relationships and relationships as a source of strength. Concerning the former, one participant explained, “I would tell my husband don’t touch this, don’t touch that, don’t help that person because you will get dirty, you will touch something that I will touch later... I hurt the people around me.” Another person described the following immediate and obvious connection between OCD and his social isolation:

When I was 11, I started being obsessed with people. I would follow them, go on their rooftops to spy on them, see if they were in or out ... I thought that was love. I now think of it as pathetic. That’s the only time when I actually wanted to die. Now I avoid having a partner, friends, any people that might involve taking a next step.

However, relationships were not simply a source of concern. The influence of the extended family network was ultimately what prompted the participant with the highest Y-BOCS score to seek help. She remarked, “I was desperate and a niece of (my doctor) is a friend of my niece and she told me to see him. I’m famous in my family, when we are together they yell, stop washing, come and sit down, you’ve washed enough. They ‘kid’ about it with me, they make jokes, so this girl referred me to him.” This same individual, who also suffered from religious obsessions or scrupulosity, also provided a detailed description of the support she received from her mother:

My mother always told me ... God is not going to be angry if you don't kiss the images. They are just images (and) God is everywhere—you don't have to do this (compulsive rituals), nothing is going to happen. She helped me a lot ... she always tried to get me not to do things. She would take me away from the kitchen or say, enough. She gave me a lot of security.

All of the participants identified at least one person as a source of emotional support, including the least verbal of the interviewees, who stated, “when my grandfather was alive ... he encouraged me and even took me to the doctor.” When asked what was most helpful in coping with their OCD, participants most often mentioned support from family, followed by knowledge about their disorder, strength of will, medications, and being active or “doing something.”

Discussion

The aim of the study, which was to provide preliminary data and to determine the feasibility of study procedures, also frames the discussion. As to the study procedures, these proved easy to follow—interviews were completed in the allotted time and mostly minor clarifications were needed in wording of certain items on the demographic tool and the OCD-SSGI. The one exception on the demographic tool was an item that asked participants to describe their ethnic and racial background. Two participants were visibly irritated by this question and one replied, “Do you think that I'm a racist?” Further probes revealed that the individuals were unfamiliar with this type of question and regarded themselves as purely Mexican. This item was clarified by adding standard ethnic/racial categories from which the participant could choose. One item on the SF-36v2 also proved confusing for some participants (“During the past 4 weeks, have you ... cut down on the amount of time you spent on work or other activities?”). Because OCD-related rituals may increase the time spent on various activities and result in less productive time, the research team agreed to clarify this item by explaining that this item refers to amount of “productive” or “meaningful” time spent on work or other activities. None of the participants demonstrated any difficulty related to understanding the language used in the four study tools.

The data from the six participants both confirmed certain aspects of prior research and added unique insights. The distribution between males and females, for example, is consistent with current understanding that OCD affects men and women equally (Jenike, 2004). The participants' symptoms were also consistent with the kinds of obsessions and compulsions reported by persons with OCD in different parts of the world. The only slight surprise, given that symptom content can reflect cultural variations, is that in a region where Catholicism has been described as having a pervasive influence, only one person reported symptoms involving scrupulosity. Perhaps this is due to sample size, or maybe religious themes are not as powerful as might have been thought in shaping OCD content along the Border.

More striking is the impact that OCD has had on the quality of life of the participants, as measured by the SF-36v2. Their mean physical component summary score is actually slightly above the U.S. mean, although substantially below the mean established in two Mexican states by Durán-Arenas and colleagues (2004). However, the difference between the mental component summary for the sample and the U.S. and Mexico norms is dramatic. The sample mean is 27.91, compared to 50.0 for the general U.S. population and 76.7 for the general population of Oaxaca and Sonora in Mexico. It is also lower than the 29.21 reported by Bobes and colleagues (2001) for 36 clients with OCD in Spain, below the mean reported for a sample of 362 Spanish outpatients with chronic schizophrenia (Bobes et al., 1998), and below the mean for 60 U.S. persons with OCD reported by Koran and colleagues (1996). This suggests that OCD has had a major negative impact on the lives of the six persons in the current sample. Age is probably not a factor in the lower scores as the mean age of the current sample was similar to that of both the U.S. and Spanish samples.

The subscale scores for this Border group were similar to the sample from Spain, but different from the U.S. OCD study. Their mental health and social functioning mean scores were lowest, followed by role emotional and vitality. For the Spanish sample, role emotional was lowest, followed by nearly identical scores for mental health and vitality, and then social functioning. In the U.S. sample of persons with OCD, social functioning was rated similarly to general health, well above both the Spanish and Border samples. Bobes and colleagues (2001) suggested that the statistically significant difference that they found between the U.S. and Spanish samples in the area of social functioning may be due to the greater importance attached to the social component in Spain versus in the US. The preliminary data from this Border sample of Mexican American and Mexican persons with OCD adds strength to this suggestion, particularly when viewed alongside the data from the semistructured interviews. As described under results, issues involving relationships were emphasized by all of the participants. Without exception, the interviews showed that relationships were a key to their ability to cope and that these relationships were a source of challenge and concern. Overall, this preliminary data suggests that quality of life for persons at the Border is highly impaired, perhaps more so than even persons with other chronic neurobiological disorders such as schizophrenia. But the neurobiology of OCD is only part of the challenge to quality of life and the challenge of having OCD, as the interviews revealed.

Life at the Border for Mexican Americans and Mexicans with OCD seems to present unique challenges and opportunities. As described in the background, this is a region of relatively scarce health care resources. An informal survey of psychiatric-mental health providers by members of the research team revealed no providers with in-depth experience and knowledge in the specific cognitive behavioral treatment approaches for clients with OCD. Even if such providers were available, however, only one person in the sample had private health insurance; one had insurance through the social security system in Mexico; and the remaining four were either uninsured or covered only by the sector of Mexico's national health care system generally reserved for impoverished persons. Two persons earned less than \$5,000 per year; another earned less than \$15,000; and two others earned less than \$25,000 per year. Regular access to a skilled cognitive-behavioral therapist, a proven treatment approach for OCD, was simply not a possibility. Within this sample, then, individuals were most fortunate if they could simply obtain an appropriate medication for OCD. Only two of the six participants were in this category.

Poverty, inadequate insurance and lack of resources all highlight the reality of health disparities at the Border, particularly for Mexican Americans and Mexicans with chronic health problems. Persons with OCD are challenged even more. A therapeutically useful conceptualization of this condition has been achieved only in approximately the past two decades, although OCD symptoms have been recognized for more than 300 years (Berrios, 1996). Moreover, shame tends to accompany OCD, causing sufferers to hide their condition, to the extent that the most seriously ill seldom if ever leave their homes. In addition, psychiatric-mental health conditions seem to be singularly forgotten at the Border. The most recent conference of the U.S.-Mexico Border Health Association (June 2005) provides one example. The conference brought together health care providers and researchers from both sides of the 1,900-mile U.S.-Mexico Border for 4 days of numerous health-related presentations, but only one dealing with a psychiatric-mental health condition. The lone presentation was a poster by this research team on OCD. No wonder that the participants in this pilot study regarded the chance to be interviewed, and the brief newspaper article that described this research in a local Spanish-speaking newspaper (Olson, Vera, & Perez, 2005b), as an opportunity and significant advancement in care. As the first participant explained,

With this opportunity (referring to the interview) I now will be able to know what is happening to me and maybe see the help I need ... I like life on the Border, when I

had to go back to Veracruz I saw the difference and I could see that the mentality there is closed. I would never expect to see something like you had in the newspaper.

Conclusion

The widespread and devastating nature of OCD sharply contrasts with the paucity of research involving Mexican Americans and Mexicans who suffer from this condition, particularly in relation to culture, ethnicity, health disparities, and quality of life. This study was a small but important step toward addressing this knowledge gap in the underserved region of the U.S.-Mexico Border. Although it is not possible to generalize from such a small sample, the data obtained emphasize the need for continued study. Such study should include not only a larger sample, but also further investigation of themes and issues related to culture, ethnicity, and OCD. More in-depth examination of general challenges involving psychiatric-mental health care at the Border is needed as well, along with exploration of the political and ethical concerns involved in Border health care. These areas of investigation are at the core of nursing's commitment to providing culturally competent care to underserved populations, and are crucial to the ultimate goal of developing culturally sensitive interventions to decrease health disparities involving OCD.

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TABLE 1

Summary of Care and Treatment per Subject

Subject	Therapy/Provider	Medications/Herbs
301	Hypnotist/psychologist; Neurotics Anonymous support group	St. John's wort; valerian root
302	Psychiatrist (diagnosis only)	None currently (previous: paroxetine ^a)
303	Psychiatrist (diagnosis & medication management)	Clomipramine, clonazepam ^a
304	Psychiatrist (diagnosis & medication management) (previous: cognitive behavior therapy [?] ^b ; hospitalization)	Clomipramine, carbamazepine ^a
305	"Government doctor" (diagnosis only)	None
306	Unspecified physician (diagnosis & medication prescription)	None currently (previous: unspecified anti-depressant [?] ^b ; valproic acid; lithium; risperidone)

^aClinically proven treatment for OCD.

^bPossible effective treatment—unclear description from subject.

TABLE 2

Cultural Identification (SASH),^a Symptom Severity (Y-BOCS),^b and Quality of Life (SF36v2 Summary Scales: PCS and MCS)^c per Subject

Subject	SASH	Y-BOCS	PCS	MCS
301	19	25	48.04	19.97
302	18	32	62.72	16.75
303	21	17	51.47	34.29
304	22	22	43.40	41.79
305	21	29	52.90	22.30
306	43	23	57.90	32.38
Mean	24 (more Hispanic)	24.66 (severe)	52.74	27.91
SD	4.89	4.96	6.89	9.72

^a SASH scoring is based on 0–60 points possible for 12 items using a 5-point Likert scale; scores lower than 36 suggest greater identification with Hispanic culture, while higher scores suggest greater identification with Anglo culture.

^b Y-BOCS scale: 0–7 = subclinical; 8–15 = mild; 16–23 = moderate; 24–31 = severe; 32–40 = extreme

^c PCS = Physical Component Summary; MCS = Mental Component Summary. The norm for the general U.S. population on the PCS and MCS scales is 50.00; the norm for the general Mexican population, based on the states of Oaxaca and Sonora, is 79.0 for the PCS and 76.7 for the MCS.

TABLE 3Major OCD Symptoms per Subject^a

Subject	Obsessions	Compulsions
301	Harming others	Counting; hoarding
302	Dirt; religious images	Cleaning & washing; checking; religious rituals
303	(unclear from interview)	Repeating; counting ^b
304	Bodily waste; dirt	Cleaning & washing
305	(unclear from interview)	Repeating; touching ^{bc}
306	Ordering/symmetry	Ordering/symmetry rituals; perfect handwriting

^aSymptoms were listed only if they were time consuming and resulted in clinically significant impairment or distress.

^bRefers to doing certain activities a particular number of times.

^cNeed to touch certain items or people.