This paper summarizes a variety of assessment tools for use with obsessive-compulsive disorder (OCD) and obsessive-compulsive (OC) spectrum conditions. The description of instruments and methods of assessment is intended to help clinicians identify measures that might be especially useful in determining, first, what problems to address in treatment and, second, whether therapy is having the desired effect. Included are clinician interviews, self-report questionnaires, clinician-rated forms, and behavioral observations and self-monitoring by the patient. These cover patients’ presenting symptoms, comorbid conditions, mood, ability to function, family aspects, and cognitive factors including insight, beliefs, and motivation. Clinicians are encouraged to provide immediate feedback about patients’ responses to interviews, questionnaires, and behavioral measures so that they understand the purpose of the instrument and its relevance to their treatment. [Brief Treatment and Crisis Intervention 3:169–185 (2003)]

KEY WORDS: measurement, behavioral measures, interview, self-report, family assessment.

Overview of Clinical Assessment

Assessment for obsessive-compulsive disorder (OCD) and obsessive-compulsive (OC) spectrum disorders has multiple purposes, such as establishing rapport by asking sufficiently detailed questions during interviews and by requesting completion of relevant questionnaires so that the patient feels well understood by the clinician. These questions also allow both parties to identify the main treatment goals and the symptoms that will be the primary focus of the therapy. Detailed information also enables the clinician to develop a careful formulation of the case with regard to causal and moderating aspects, as well as specific targets for the therapy. These factors include those that play a role in the symptoms, such as thinking, emotional reactions, and functional behaviors. Assessment also helps provide an indication of the patient’s motivation for therapy, even with regard to willingness to complete forms.

The assessment also helps determine what
type of treatment is most acceptable to patients and most likely to provide a good outcome. Treatments under consideration are described in this volume include behavior therapy, cognitive therapy, serotonergic medications, and possible alternative therapies. Interview questions help determine whether behavioral and/or cognitive strategies are best delivered by a therapist or via homework assignments; with or without family assistance; and in group or individual settings. The therapist can also identify possible impediments to therapy—for example, a spouse who doesn’t believe therapy is needed. Repeated assessments also provide critical information regarding progress during therapy and treatment outcome so that wise decisions can be made regarding the continuation of ongoing interventions or altering the treatment plan.

Multiple methods of assessment are commonly used for OCD and spectrum conditions, including formal diagnostic interviews, as well as interviews for gathering clinical information. Self-report methods include questionnaires relevant to the main symptoms and to related psychopathology, such as mood, beliefs, comorbid conditions, and functioning. In addition, patients are often asked to keep records of their actual behaviors, thoughts, and emotions as they are occurring in real time. In some cases (e.g., children), other people such as family members or teachers may be asked to keep records of the patient’s behaviors. These multiple methods of assessment provide an integrated view of the symptoms and surrounding context that will be useful in therapy. Assessment focuses on the full range of information that might be pertinent to the therapy process. These data include lifetime and current diagnoses, current OCD and spectrum symptoms, and history of the problem and important life events associated with changes in course. In addition, information is sought about cultural context, including religion and ethnicity, current and past functioning with regard to social and family life, work and leisure activities, and comorbid conditions that might influence treatment efforts. Also assessed are family support, beliefs (including insight), and attitudes about the problem and therapy, as well as the patient’s motivation.

The present paper is not intended as an exhaustive presentation of assessment strategies or their psychometric properties. Here we simply present instruments we consider most useful and convenient for clinicians in a variety of public- and private-practice settings. Formal measures are given in italics for easy identification. Readers wishing detailed reviews of measurement instruments relevant for OCD are referred to Feske and Chambless (2000), Taylor (1998), and Antony, Orsillo, and Roemer (2001).

Determining Diagnosis and Comorbidity

Why Diagnose?

The symptoms of OCD and OC spectrum conditions manifest themselves on a continuum that ranges from no symptoms to mild subclinical problems to serious diagnosable disorders. Generally, those who experience these symptoms do not seek treatment until symptoms are moderate in severity, and most will qualify for a diagnosis of the disorder. Diagnostic criteria provided in the Diagnostic and Statistical Manual of Mental Disorders-Version IV (DSM-IV) provide a common language for mental health clinicians. Formal diagnostic interview schedules are available to assist clinicians in diagnosis. Most useful are those that include all relevant symptoms, distinguish between potentially overlapping conditions, and also permit quantification of severity of symptoms.

The Anxiety Disorders Interview Schedule (ADIS; DiNardo, Brown, & Barlow, 1994 [adult version]; Silverman, 1991 [child version]) is particularly useful for diagnosing OCD because it
permits the clinician to determine the type and severity of presenting obsessions and compulsions, including frequency, persistence, distress, and resistance associated with these symptoms. This level of detail helps determine which symptoms should be treated first. The ADIS also includes sections to identify environmental stressors (family, work, finances, health) and insight into obsessive fears consistent with new DSM-IV criteria for the insight modifier. The ADIS includes diagnostic questions for hypochondriasis but not for most OC spectrum conditions. Another common research diagnostic instrument is the Structured Clinical Interview for DSM-IV Patient version (SCID-P; First, Spitzer, Gibbon, & Williams, 1995). Like the ADIS, this instrument determines whether subjects qualify for a diagnosis of OCD, and it identifies comorbid conditions. It also includes a Global Assessment of Functioning (GAF) scale that allows the clinician to record the patient’s level of functioning on a scale from 1 to 100 according to specific anchor points. The SCID also permits diagnosis of hypochondriasis and body dysmorphic disorder (BDD) but not other spectrum conditions like trichotillomania and Tourette’s syndrome.

**Identifying Comorbidity**

The diagnostic instruments described are useful for determining the presence of comorbid conditions that clinicians need to be aware of during treatment. Most commonly, these conditions fall into the anxiety and mood disorders groups, but occasionally other types of comorbidity may merit concern. The Anxiety Disorders Screen developed by the Anxiety Disorders Clinic at New York State Psychiatric Institute (New York, NY) has been used for public health screening of anxiety disorders, and it provides a few important questions to help identify the presence of panic symptoms and agoraphobia, social phobia, and generalized anxiety disorder, as well as posttraumatic stress symptoms. If these symptoms are detected via the brief screen, specialized self-report instruments can then be used to further determine severity of these conditions. A good source for such instruments is Antony, Orsillo, and Roemer (2001).

Mood disorders, especially major depression, are common accompaniments to OCD and spectrum conditions, especially when the OC disorder is severe. In addition to diagnosing these via the ADIS or SCID, clinicians can use the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960), a 17- or 21-item interview measure for detecting significant depression. Alternatively, the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988) can be used to collect self-report information about the severity of depression. Evidence of reliability and validity for the BDI is well established (Beck et al., 1988). Other questionnaire measures of depression are available in Nezu, Ronan, Meadows, and McClure (2001). Depression is unlikely to lead to modification of the treatment plan unless the patient is seriously suicidal or the depressed mood causes substantial interference with the patient’s ability to complete treatment requirements.

Other types of comorbid conditions that might alter treatment planning can be detected with standard diagnostic interviews. Screening tools are available in the ADIS and SCID interviews for detecting psychotic conditions and substance abuse, and in the SCID for identifying eating disorders. Personality traits and disorders are often difficult to diagnose reliably. Because interview measures are quite time consuming for this purpose, we recommend the use of self-report instruments (with the risk that they may lead to overdiagnosis). One such commonly used instrument is the Personality Diagnostic Questionnaire (PDQ; Hyler et al., 1988), which has been found to have adequate reliability and validity (Hyler, Skodol, Kellman, Oldham, & Rosnick, 1990). Another is the Struc-
tured Clinical Interview for DSM for Personality (Spitzer, Williams, Gibbon, & First, 1990). It is noteworthy that avoidant and dependent traits are commonly diagnosed in OCD and spectrum disorders (e.g., Steketee, Henninger, & Pollard, 2000). As compared to OCD, patients with BDD tend to have many more personality disorders (McKay, Neziroglu, Todaro, & Yaryura-Tobias, 1996; Neziroglu, McKay, Todaro, & Yaryura-Tobias, 1996). Percentage of patients who met diagnosis for at least four personality disorders include 38% for OCD and 75% for BDD. Avoidant and dependent personality disorders do not present serious problems in treatment, so long as therapists do not routinely reinforce dependence but instead actively encourage independent decision-making and coping skills. More troublesome may be conditions such as obsessive-compulsive personality disorder, as well as schizotypal, schizoid, and borderline personality disorders, which may present therapy-interfering behaviors or social interaction problems that require specialized interventions. Because several of these disorders occur frequently among patients with BDD, it is important to address them in this disorder.

Because diagnosis of the index disorders and comorbid conditions is important in designing the therapy, it is often helpful to obtain collateral information from close family members and other observers in school, home, or social settings, where symptoms are evident. Obtaining information from observers is obviously subject to ethical constraints on the therapy, as well as to the therapist’s understanding that some observers may hold views that bias their reporting, just as do patients. Nonetheless, independent observers can often provide important information about diagnostic conditions and about the nature of the primary complaint to supplement the clinical interview as described in the following sections.

Understanding the Problem: The Clinical Interview

OCD Symptoms

The therapist’s primary task in the initial assessment is to identify and understand the main symptoms that are causing the patient concern. In the case of OCD, this objective includes questions to elucidate the types of intrusive thoughts, images, and impulses that have become full-blown obsessions. Equally important is an understanding of the cues that trigger these obsessions, including internal cues (mental ideas and images, physical sensations, and perceptual experiences), as well as external ones (touching certain items, observing objects or events). These triggers are usually accompanied by feared consequences that the patient expects to follow the experience, and these consequences are often exaggerated or catastrophic (illness, harming others, moral or legal liability, etc.). To correct or reduce these obsessive fears, patients commonly engage in compulsive behaviors or ritualized coping strategies that interfere with normal functioning. Freston and Ladouceur (1997) define these as any voluntary or effortful mental or physical action performed with the goal of controlling or removing the thought, changing its meaning, preventing negative consequences from occurring, decreasing negative mood, or preventing further occurrences of the thought. The therapist can ask specific questions to identify behavioral rituals, mental rituals, and other types of coping strategies. Of course, some patients who may not have any identifiable thoughts do report compulsions, which is especially true in children.

Other aspects of the symptom picture that require specific assessment include the degree of insight into the irrationality of the patient’s own behaviors. For OCD, therapists can ask the patient to describe the likelihood of x happening
in the event of \( y \) happening: “How likely do you think it is that [the feared consequence] will actually occur if you actually [experience a common trigger]?” For example, “How likely do you think it is that you will actually develop hepatitis if you touched the toilet seat in a public bathroom?” or “How likely do you think it is that you would actually throw your child out the window if that image popped into your mind?” The therapist can solicit the likelihood in terms of percentage and then clarify that the patient has understood the question clearly. For example, “You said ‘20% likely,’ so that means you think that the [catastrophe] will definitely occur in 2 of every 10 situations (or 1 in 5 cases). Is that what you mean?” Formal interview methods for assessing insight are described in the subsequent sections of this paper.

The therapist will also want to determine what types of avoidance behaviors commonly accompany the experience of obsessions and fears associated with OC spectrum conditions. Because avoidance is harder to recall than overt behaviors, reference to earlier times when symptoms were not present may help elucidate current avoidance patterns. In addition, the therapist may find it helpful to ask patients to describe a typical day in their lives to help put the obsessive thoughts, avoidance behaviors, and rituals into perspective with regard to type, frequency, and severity, as well as interference in functioning.

**OC Spectrum Symptoms**

For a disorder to be considered part of the OC spectrum, obsessions and compulsions must be primary symptoms. To date, the most widely studied spectrum disorders are body dysmorphic disorder (BDD), hypochondriasis (HC), trichotillomania (TM), and Tourette’s syndrome (TS). Although other disorders such as eating disorders, pathological gambling, compulsive self-mutilation, and sexual perversions have been considered part of the spectrum, few data support this connection (Hollander, 1993; Yaryura-Tobias & Neziroglu, 1997a, 1997b). For this reason, we will limit this article to the most widely studied disorders. Readers are referred to articles in this issue by Neziroglu and Khemlani-Patel on BDD; by Mansuedo and Stein on trichotillomania; by Salkovskis, Warwick, and Deale on hypochondriasis; and by Deckersbach, Keuthen, and Wilhelm on skin picking and related conditions.

Most patients with BDD and HC come reluctantly for psychological treatment because their insight is very limited; that is, they have more overvalued ideas compared to OCD patients (Neziroglu, McKay, & Yaryura-Tobias, 2000; McKay, Neziroglu, & Yaryura-Tobias, 1997). It is often treatment failure with internists, dermatologists, and cosmetic surgeons that leads HC and BDD patients to seek psychological treatment. Even when they do seek help, it is often for depression, anxiety, and/or inability to function. Therapists need to probe for the symptoms by asking relevant questions. For example, to elicit BDD symptoms, clinicians can ask: “Have you ever been concerned with your looks? Do you spend a lot of time checking or avoiding looking at the mirror? Have you ever not gone some place because you disliked the way you looked? How important is attractiveness to you?” The following questions may be helpful to elicit hypochondriacal symptoms: “Are you concerned with physical symptoms? Do you ever think that you have a tumor, multiple sclerosis, or any serious medical illness? How often do you call doctors or visit them?”

Patients with TM are embarrassed about their behavior and feel misunderstood by many professionals, although their insight is usually good and they want help. Hair-pulling behavior may involve the scalp, eyebrows, eyelashes, pubic region, face, or any part of the body. Stanley, Swann, and Bowers (1992) suggested that the experience of pleasure reported by many pa-
patients during hair pulling differentiates this population from those with OCD. Also, many TM patients do not exhibit any other OCD symptoms. Keuthen and colleagues (1998) provide an excellent review of treatment outcome on those who pull their hair. To better focus the treatment with TM patients, it is important to assess at what point they become aware of their pulling behavior.

Patients with TS usually do not hide their symptoms and, unlike TM patients, are generally not embarrassed by their tics and twitches—although they are distressed and eager to do everything possible to reduce their symptoms. Often, the problem is determining whether someone in fact has TS. Tics and vocal sounds may be transient and not indicators of TS. In children, these symptoms may disappear altogether, so it is necessary to wait and see whether symptoms progress. If tics, twitches, vocal sounds, echolalia, and copralalia are present, a diagnosis of TS may be given. Many TS patients also have other obsessions and compulsions, and a link on the X chromosome has been found between TS and OCD (Pauls, 1992).

Assessing History and Functioning

As for all types of mental health problems, it is important for the therapist to question the patient about the onset of the problem and the surrounding events so that he/she can obtain an understanding of the historical course of OCD and OC spectrum conditions, as well as their effect on functioning. In addition, the therapist will want to inquire particularly about family psychiatric history with regard to current symptoms and other related conditions, such as anxiety and mood disorders. Often, family members may have had subclinical levels of OCD or OC spectrum conditions, even if they would not have been formally diagnosed with the condition. Questions about previous mental health treatments—including medications, behavioral therapy (using exposure and response prevention or other methods), cognitive therapy, and other forms of psychotherapy—will help the therapist understand the degree to which the patient will respond well or poorly to suggestions for current treatments. In addition, if the patient used other coping methods to manage the symptoms, such as substance use or seeking reassurance from others, the therapist will want to determine whether these strategies could prove problematic for the current therapy.

Most assessment interviews include questions about the patient’s general history, including medical history and current medical conditions, educational experiences, and employment patterns. Assessing the patient’s current family situation and relationships helps the therapist understand the degree of emotional support family members provide, as well as the degree of criticism, hostility, and accommodation to the patient’s needs that family members provide. Standardized assessment of family accommodation is also provided in the following sections. Social relationships and the general social support of friends may prove important in understanding coping abilities during the planned therapy. In the context of family and social history, it is important to determine sexual history and current sexual functioning, especially if sexual obsessions or spectrum concerns (e.g., for BDD) are present. History of traumatic experiences may have some bearing on OCD or OC spectrum symptoms. Family members’, friends’, and personal attitudes toward therapy are likely to be important, as are cultural, ethnic, and religious identification, experiences, attitudes and beliefs. Thus, the therapist will want to assess a wide variety of components of the patient’s personal and social life to fully understand the symptoms and the type of therapy that is most likely to alleviate problems and encourage effective coping.
Standardized Measures of Severity

A variety of standardized measures intended to quantify the types and severity of presenting symptoms are available to clinicians. Here, we present measures commonly used in research studies to assist the therapist in interpreting findings from this research. More importantly, the instruments described are ones we consider especially useful for understanding the patient’s symptoms and for planning treatment in clinical practice.

Measures of OCD Symptoms

The Yale Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989) includes both a symptom checklist and a scale that assesses severity of OCD symptoms. Although traditionally administered as an interview by experienced clinicians, a self-report form is also available (in Baer, 1991). Steketee, Frost, and Bogart (1996) determined that the two forms were approximately similar in psychometric properties, although patients tended to rate themselves somewhat lower than clinicians did. The symptom checklist is particularly useful in helping clinicians identify 36 types of obsessions and 23 types of compulsions, covering the following types of symptoms: harming, contamination/washing, sexual, hoarding/saving, religious, symmetry/exactness, somatic, and miscellaneous. In addition, some symptoms of OC spectrum conditions (e.g., TM, HC) are also included. The 10-item scale then assesses the degree of difficulty regarding time spent, interference, distress, resistance, and control of the patient’s most common obsessions and compulsions from the checklist. These five items are rated on 0–4 scales for both obsessions and compulsions. The following scoring is considered standard: 0–7, subclinical; 8–15, mild; 16–23, moderate; 24–31, severe; 32–40, extreme. But clinicians should be aware that patients who predominantly have obsessions and few mental or overt rituals may score lower despite substantial severity of symptoms. Most commonly, patients seeking treatment in research studies must have a total score of 16 or above to qualify, and it is common for patients both in medication and in cognitive and behavior therapy studies to have average pretreatment scores in the range of 22 to 26. Patients are considered to have successful outcomes when their scores drop below 15, and some studies have achieved average posttreatment scores in the range of 10 to 12, which is well below the clinical cutoff for study entry (see Franklin, Abramowitz, Kozak, Levitt, & Foa, in press). For those who mainly have obsessions, their initial and posttreatment scores on the Y-BOCS will be noticeably lower.

Symptom subtypes have been examined by several investigators using the Y-BOCS checklist (e.g., Leckman et al., 1997; Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999; Summerfeldt, Richter, Antony, & Swinson, 1999). These investigations have generally concurred that OCD symptoms cluster in the following ways: obsessions and checking; symmetry and ordering; contamination and cleanliness; and hoarding. These groupings may prove useful to clinicians in that some subtypes might best be treated together using behavioral or cognitive methods. Patients with several disparate types of symptoms, however, may require additional treatment to address all components. A children’s version of the Y-BOCS (C-YBOCS; Scahill et al., 1997) is also available. As for adults, childhood symptoms also tend to cluster, although the pattern is somewhat different from that for adults. McKay et al. (submitted) identified four factors: obsessions, compulsions, superstitions, and hoarding/ordering/somatic concerns. Several symptom domains significantly contributed to more than one subtype. Based on recent findings, some revisions and variations of the Y-BOCS are...
currently under construction and are likely to appear in the literature in the next few years.

The Padua Inventory (Sanavio, 1988) is a 60-item measure that has shown good reliability and validity across clinical and nonclinical samples (Goodman & Price, 1998). Two briefer versions of this measure are available. In our research, we have used the Washington State University revision (PI-R; Burns, Keortge, Formea, & Sternberger, 1996), which consists of 39 items that assess the frequency and severity of obsessive and compulsive symptoms. This measure has acceptable indices of reliability and validity (Taylor, 1998), and it tends to be a purer measure of OCD symptoms than the original (Burns et al., 1996). In addition to a total score, the PI-R includes five subscales: thoughts of harm to self or others (7 items); impulses of harm to self or others (9 items); contamination and washing (10 items); checking (10 items); and dressing and grooming (3 items).

The Obsessive Compulsive Inventory (Foa, Kozak, Salkovskis, Coles, & Amir, 1998) has been developed more recently and has both a long form (42 items) and a short form (18 items; Foa et al., 2002), which are highly correlated. This instrument is gaining in popularity, and the short form has good psychometric properties, as well as subscales for both versions covering checking, hoarding, neutralizing, obsessing, ordering, and washing. In a large clinical sample, subscales showed good internal consistency, test–retest reliability, and convergent validity with other measures of OCD symptoms.

The NIMH OC Scale (Insel et al., 1983) is a single-item, 15-point rating scale (1 = minimal symptoms, 15 = very severe) completed by clinicians of the overall severity of OCD symptoms. Although limited study of its psychometric properties has been done, this scale is easily used clinically and has been widely adopted in psychiatric research, especially in medication studies of OCD.

The Maudsley Obsessional-Compulsive Inventory (Hodgson & Rachman, 1977) has been used frequently in research trials. This brief, 30-item questionnaire provides a total score and four subscales that assess checking, washing, doubting/conscientiousness, and slowness/repetition. In general, it possesses good test–retest reliability and good internal consistency and adequate validity (Emmelkamp, Kraaijkamp, & van den Hout, 1999). Although the original developers have revised and expanded this measure (now called the Vancouver Obsessional Compulsive Inventory; Thordarson, Radosmy, Rachman, Shafran, & Sawchuk, 1997) to be more comprehensive, it has not yet been widely adopted.

Likert-type Target Rating Scales on which patients and therapists rate the severity of specific OCD symptoms targeted in treatment have been commonly used in behavioral treatment trials to assess outcome. These scales have shown reliability among raters, and they are highly sensitive to treatment effects, although they may be less stable than desirable. Use of these scales is recommended only in conjunction with other standardized instruments (see Feske & Chambless, 2000).

Measures of Severity of Spectrum Conditions

The Y-BOCS has been modified for use with BDD patients (Phillips et al., 1997). While similar to the original Y-BOCS, it is divided into two subscales. Excellent interrater reliability has been established, as has convergent validity, and this instrument has proved useful for assessing treatment outcome. Three factors identified included core symptoms, compulsions, and resistance/control of thoughts. Another widely used instrument is the Body Dysmorphic Disorder Examination (BDDE; Rosen & Reiter, 1996), which is a 34-item semistructured measure administered by a clinician. The BDDE aids in the diagnosis of BDD, and it also
provides a detailed description of symptoms in several areas. These symptoms include preoccupation with and negative evaluation of appearance; self-consciousness and excessive importance placed on appearance in evaluating oneself; avoidance of social situations or activities; body camouflaging; and checking/reassurance-seeking behaviors. It has good reliability and validity, and it effectively assesses change following treatment.

The severity of hypochondriacal symptoms has been measured with a modified version of the Y-BOCS (Neziroglu & Anderson, 1997; Neziroglu, McKay, & Yaryura-Tobias, 2000). However, this version did not appear to be a satisfactory measure because, although the obsessive scale proved adequate to assess HC symptoms, the compulsions scale did not.

The Massachusetts General Hospital Hair-pulling Scale is a seven-item scale that measures the severity of TM (Keuthen et al., 1995). Questions inquire about the frequency and intensity of urges to pull hair, the ability to control urges, the frequency of hair pulling, the resistance to hair pulling, the ability to control hair pulling, and associated distress. Each item is rated 0 to 4, depending on severity. This scale appears useful for measuring changes in symptoms over time.

Yale Global Tic Severity Scale (Leckman et al., 1989) can be used to measure the severity of TS and other tic disorders. This semistructured interview scale is divided into motor and vocal tics, and each subscale measures the number, frequency, intensity, complexity, and interference of the tics. It is designed to elicit information concerning the specific character and anatomical distribution of tics observed during the course of a 1-week interval before the clinical assessment. It also measures the frequently associated symptoms of behavioral problems, motor restlessness, and school/work impairment. Reliability and validity have proved good.

Mood and Disability Scales

Several instruments are commonly used to provide information about moodstate and current functioning. Measures of depressive symptoms have been noted in the previous sections and include the Hamilton Rating Scale and the 21-item BDI. Both have been widely used in clinical studies, both have good psychometric properties, and both provide guidelines for interpreting severity of depression to help clinicians determine whether special attention may be needed to this problem. The most commonly used measures of general anxiety are the Spielberger State-Trait Anxiety Inventory (Spielberger, 1983)—which includes 20-item scales for either state (usual) or trait (current) anxiety—and the 21-item Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988). Consistent with their primary diagnosis, patients with anxiety disorders who complete these measures usually exhibit substantial anxious mood that declines with successful treatment.

Current functioning can be assessed with the Sheehan Disability Scale (Leon, Shear, Portera, & Klerman, 1992). This brief, self-report scale assesses work; social life and leisure activities; and family life and home responsibilities on scales ranging from 0 (not at all) to 10 (very severely; cannot function). Overall disability is rated on a 5-point scale. It has been used in a variety of pharmacological studies, and it showed acceptable reliability and validity. Leon et al. (1992) reported good reliability and validity for this scale.

Observational Measures

Actual observation of rituals and avoidance patterns in natural settings such as the home, public places, or workplace is often an invaluable source of information about the patient’s behavior. Unfortunately, this task is often diffi-
cult to accomplish for clinicians who have little time to travel with patients to their homes, and it may be inappropriate for patients to be seen with a therapist in their place of work. However, it is often possible for the therapist to observe the patients’ behaviors in nearby public places, such as their actions in restrooms (for those who have certain types of contamination fears) or their walking down the street (if doing so elicits obsessive concerns). Likewise, it may be useful to accompany a patient with BDD to observe other’s reactions and then inquire about the patient’s experience of these reactions to identify the extent of insight into imagined slights. Real situations are important cues for most patients with OCD and spectrum conditions; whenever the therapist can observe responses firsthand, doing so can therefore provide useful information in understanding the symptoms and for designing appropriate treatments.

Behavioral and cognitive therapies commonly employ self-monitoring, or self-recording, of obsessions, rituals, distress, and avoidance behaviors that occur on a daily basis. Ratings of distress called subjective units of discomfort usually range from 0 (no discomfort) to 100 (maximum/extreme distress). These strategies are invaluable for understanding the patient’s experience of symptoms in real time and for tracking possible cues that precede symptoms, and they may be important to include in exposure therapy. A frequency count of obsessions and/or rituals is commonly used. But when symptoms are lengthy, rather than frequent, recording the duration of an obsession or ritual may be more relevant. When obsessive thoughts or rituals (e.g., checking or repeating) are too numerous to count, daily estimates of the total duration can be made, or the patient can time-sample their presence during preselected hours. These types of self-monitoring of symptoms permit the patient and therapist to observe immediate progress and even track this in graphic form.

Behavioral Avoidance Tests (BAT) have been commonly used to assess behavioral responses in phobic and panic disorders, but they are harder to design for OCD because of the wide range of symptoms. Steketee, Chambless, Tran, Worden, and Gillis (1995) devised multitask behavioral tests for patients with widely varying symptoms of OCD. This method used up to three tasks to reflect the patient’s main obsessive fears and rituals, with each task having up to seven steps. A rater determined whether patients did the task, how much anxiety they reported, and whether they engaged in any rituals. Examples of tasks include listening to media information pertinent to obsessions about harming others, thinking bad numbers, encountering objects associated with death, doing laundry, touching money, and using public restroom facilities. The BAT demonstrated good convergent and divergent validity, as well as sensitivity to the effects of treatment. Several examples and a scoring strategy are provided in the Steketee et al. (1995) article.

Family Assessment

Clinicians will want to have some contact with family members if possible in order to obtain information about their awareness of and observations of patients’ symptoms; keep in mind, however, that some family members have never observed rituals but are aware only of the aftermath of obsessions and rituals, including negative mood and avoidance behaviors. Some are profoundly caught up in rituals by participating in washing or checking rituals, giving reassurance, or a variety of other tasks. These are part of family accommodation that can be assessed via the Family Accommodation Scale for OCD developed by Calvocoressi et al. (1995, 1999). This 12-item scale is administered by clinicians to relatives of OCD patients to assess their accommodating behaviors; it has shown good reli-
ability and validity. Because greater family accommodation is associated with more family dysfunction, family stress, and rejecting attitudes toward the patient, family interventions may be needed to address these difficulties. For example, Grunes, Neziroglu, and McKay (2001) observed that patients whose family members participated in group therapy to reduce family stress benefited more from behavior therapy than did patients whose family members were not in family treatment.

In addition to accommodation, family members’ emotional reactions can be important predictors of outcome for patients with OCD. This aspect has not yet been studied with regard to OC spectrum conditions, but it is likely to be true for these patients as well, given the broad prediction of negative outcomes of patients whose relatives are high in expressed emotion. This construct describes the presence of a high number of critical comments and expressed hostility toward the patient by family members, and it may include overinvolvement or intrusiveness into the patient’s life or daily activities. Methods of assessing these family responses are often complex and expensive (Vaughn & Leff, 1976), but some evidence suggests that a simple patient rating of relative criticism on a scale from 1 (not at all critical) to 10 (extremely critical) predicted therapy effects (Chambless & Steketee, 1999). Thus, just asking patients to rate how critical their relative is can help determine whether the therapist should address family components.

Assessing Cognitive Aspects

Insight, beliefs and attitudes, and motivation for treatment are several cognitive variables that have considerable relevance for the outcome of therapy and the conduct of treatment in OCD and OC spectrum conditions. Insight refers to the degree to which the patient is aware of the irrationality of their symptoms. In the case of contamination fears, a clinician might solicit information about insight by asking, “How likely do you think it is that the consequences you fear from touching this will actually occur? Can you give me a percent likelihood? You said 10%; that means that one person in every 10 will get seriously ill. Is that what you think?” The clinician continues with questions until it becomes clear how much the patient’s opinion about the likely consequence matches either most people’s estimations or some objective estimate of the actual likelihood. Two instruments have been published that assess the degree of insight. The Overvalued Ideas Scale (OVIS; Neziroglu, McKay, Yaryura-Tobias, Stevens, & Todaro, 1999) is a 10-item, clinician-administered scale with very good reliability and validity. It assess the severity of overvalued ideas with regard to their strength, reasonableness, fluctuation over the past week, accuracy, extent to which others share the same beliefs, attribution, insight, and degree of resistance of the belief. More overvalued ideas have been associated with poorer treatment outcome for both OCD and BDD (Neziroglu, Stevens, McKay, & Yaryura-Tobias, 2001), and BDD and HC patients have shown more overvalued ideas on the OVIS than OCD patients (McKay, Neziroglu, & Yaryura-Tobias, 1997; Neziroglu, McKay, & Yaryura-Tobias, 2000). The Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998) is a seven-item scale developed to assess delusional thinking across a wide range of psychiatric disorders. Like the OVIS, it requires clinicians to ask patients a series of questions about their attitudes toward feared consequences if they do not complete rituals. The BABS has also shown good-to-excellent reliability and validity. Because of the importance of insight as a predictor of outcome, clinicians are urged to become familiar with methods for assessing this problem.

All patients hold beliefs about themselves and the world that are derived from their family
experience, their culture and religion, and their personal experience. A group of expert clinicians has suggested that several types of beliefs are very common for patients with OCD (Obsessive Compulsive Cognitions Working Group [OCCWG], 1997). They developed an 87-item Obsessional Beliefs Questionnaire (OBQ; OCCWG, 2001, in press) that includes subscales for control of thoughts, importance of thoughts, responsibility, intolerance of uncertainty, overestimation of threat, and perfectionism. A factor analysis suggested that the scale can be reduced to 44 items represented by three domains: responsibility for harm, importance/control of thoughts, and perfectionism/need for certainty. This instrument demonstrated good reliability and reasonably good validity, although the belief scales were as strongly associated with depression and worry as with OCD symptoms.

The OCCWG (2001, in press) also developed a second questionnaire measure intended to reflect immediate appraisals or interpretations of unwanted, distressing, and intrusive thoughts, images, or impulses. The Interpretation of Intrusions Inventory (III) is a semi-idiographic, 31-item questionnaire in which respondents are first given a definition of unwanted mental intrusions, and then several examples. Participants write about two of their own recent intrusive thoughts, images, or impulses and then rate their level of belief within the past 2 weeks for each of 31 statements as they pertain to these or similar intrusive thoughts. Although the III was intended to include three subscales (importance of thoughts, control of thoughts, and responsibility), factor analyses suggest that all items load onto a single factor. Reliability and validity of the III are generally good, but it is not yet clear whether this measure offers advantages over the OBQ in capturing more immediate reactions to intrusive thoughts.

In addition to these self-report instruments, most clinicians trained in cognitive therapy use thought records to assess immediate interpretations and beliefs and/or attitudes about obsessions. The therapist uses several columns on a piece of paper to indicate the context, the content of the intrusive idea or image (obsession), the interpretation or appraisal of the meaning of the obsession, how much the patient believes this interpretation on a scale of 0 to 100, and whether or not the patient completed a compulsion. In subsequent thought records during treatment, patients may be asked to add a column to record efforts to evaluate or challenge the interpretations; after doing so, they can be asked to give a second rating of the strength of belief. These records are designed to help patients evaluate and modify their negative thinking to render the obsessions less disturbing, and they are similar to those described by Beck (1995). As with other self-monitoring forms, these records call the patient and therapist to track weekly progress during therapy in modifying problematic thinking that contributes to the maintenance of obsessions and compulsions.

As it is important to identify specific cognitions in OCD, the same holds true for spectrum disorders. For example, individuals with BDD endorse beliefs about being defective, inadequate, worthless, and alone/isolated because of their appearance (Veale et al., 1996). Similarly, they also report that looking better would produce more happiness and better feelings about themselves, and they express perfectionistic beliefs about their appearance—for example, “If there is one flaw in my overall appearance, then I feel unattractive; if my [body part of concern] is not beautiful, then it must be ugly” (Geremia & Neziroglu, 2001; see also Wilhelm & Neziroglu, 2002). Unfortunately, measures of such beliefs are not yet available, nor have assessment tools for beliefs associated with TM, HC, or TS been developed. However, one study of beliefs of HC patients identified beliefs associated with overestimation of medical threat and excessive responsibility for preventing harm (Neziroglu & Anderson, 1997).
A final area we have classified under cognitive assessment is motivation for treatment. Motivation may not always be evident from verbal report, especially if patients have entered treatment from a family member’s pressuring them or for legal reasons (e.g., when eviction is pending due to hoarding behavior). In this case, patients may report wanting treatment because it is expected of them or because they view it as the right thing to do—but in fact their behavior in missing sessions or failing to do homework belies their report. Ambivalence about changing behavior can be assessed via a self-report questionnaire, the University of Rhode Island Change Assessment Questionnaire (Greenstein, Franklin, & McGuffin, 1999). This 32-item questionnaire has four subscales measuring precontemplation, contemplation, action, and maintenance. These subscales have adequate internal consistency (Carey, Purnin, Maisto, & Carey, 1999), and they can be used to determine whether the patient is ready for treatment (the action stage) or requires some motivational enhancement procedures, such as evaluating the pros and cons of retaining symptoms and of removing them via therapy. Examples of reasons to avoid treatment include identity from symptoms, status/privilege, control over others or the environment, avoidance of responsibility, discomfort of treatment, and financial support from others or from disability payments. Examples of reasons to seek therapy include discomfort from symptoms, impairment, low self-esteem, expense, and conflict with family and others.

Summary and Comment

In this paper, we have tried to summarize a wide variety of assessment tools for use with OCD and OC spectrum conditions. This list of instruments and methods of assessment is not intended to be comprehensive, but merely to assist clinicians in identifying measures that might be especially useful in determining what problems to address in treatment and how to determine whether therapy is having the desired effect. We have included various types of measures, such as self-report, clinician-rated, and behavioral observations by the patient or others. These have covered presenting symptoms and comorbidity, moodstate, functioning, family aspects, and cognitive factors such as insight, beliefs, and motivation. Clinicians must decide for themselves what measures will be helpful on a routine basis for patients in their practice. Overall, we have rarely found patients unwilling to complete interviews, questionnaires, or self-monitoring forms before or early in treatment, as well as periodically to provide measures of progress. On the contrary, most patients appreciate our skill and knowledge in using measures that are so obviously pertinent to their situations. This scenario is especially true when therapists provide immediate feedback about patients’ replies so that they understand the purpose of the instrument and how their responses are relevant to their treatment.

References


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