Measuring Obsessive-Compulsive Symptoms: Common Tools and Techniques

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With the increased recognition of the prevalence and severity of obsessive- compulsive disorder (OCD), increased attention has been devoted to its assessment and treatment in recent years. Currently, several different methods are used to assess obsessive-compulsive symptoms, including diagnostic interviews, clinician administered inventories, self-report measures, and parent- report measures. In fact, in the past two years, numerous OCD measures have been developed and/or published. Unfortunately, it is not possible to mention all of these; so this article is limited to an overview of measures used within our child and adult OCD clinics at the University of Florida with an eye towards what one might expect at his/her initial visit to a provider.

Diagnostic Interviews.
The use of structured diagnostic interviews for the assessment of pediatric OCD is quite common in research studies (but not uncommon in general clinical practice). Diagnostic interviews can be used to assign diagnoses and differentiate between other possible diagnoses. These interviews facilitate diagnostic decisions by utilizing specific questions to assess symptoms according to Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria. Within our clinic, we use the Anxiety Disorders Interview Schedule for DSM-IV for adults and the Anxiety Disorders Interview Schedule for DSM IV Child and Parent Versions for children and adolescents. Another commonly used interview is the Structured Clinical Interview for DSM-IV. Each of these is divided into sections by disorders. Detailed questions regarding each disorder are administered only if the preliminary criteria are found. Each interview usually takes between 60-120 minutes to administer.

Clinician-Rated Instruments.
The use of a clinician-rated inventory allows trained individuals to make informed ratings of OCD-related impairment and distress in comparison to cases they have seen. Perhaps the most commonly used assessment instrument within clinical and research settings is the Yale- Brown Obsessive-Compulsive Scale (YBOCS) and its counterpart for children, the Children's Yale-Brown Obsessive- Compulsive Scale. The Y-BOCS and CYBOCS are conducted in an interview format with a trained clinician and measure OCD symptoms and severity over the previous week. The Y-BOCS and CY-BOCS consist of several parts including items querying the presence of various obsessions and compulsions and items assessing the severity of symptoms. For example, there are questions about how much time obsessions and compulsions take, as well as how much distress they cause. Scores for all items are determined by the clinician on the basis of the person's report, parent(s)/spouse's report and behavioral observations.

Self-Report Instruments.
Self-report measures have several advantages in OCD assessment as they can generally be completed quickly, independently, and administered to a number of individuals at once. They are useful as screening questionnaires, and are often employed to identify potential research participants and candidates for treatment. In addition, people may feel more comfortable completing measures independently. This can guard against the under-reporting (or over-reporting) of symptoms that is sometimes observed during a clinician-administered interview. However, there are some disadvantages. For example, an individual's response style may affect his assessment of symptoms based on different interpretations of choices such as "sometimes" or "often." In addition, some respondents may have difficulty understanding the format or wording of the questionnaire, while others may not use adequate care when completing the questionnaire. Finally, the broad and variable range of symptoms in OCD may result in an underestimate of a person's impairment because specific and/or idiosyncratic symptoms may not be included in the

measures.

At the University of Florida OCD Clinic, we use the Florida Obsessive Compulsive Inventory (FOCI) and the Obsessive Compulsive Inventory- Revised (OCI-R) for self-reporting of symptoms. In the FOCI is a symptom checklist and five questions that assess symptom severity and impairment. In the checklist, the individual marks the presence or absence of 20 common obsessions and compulsions (ten each). On the severity items, the individual rates the cumulative severity of endorsed symptoms on five items: time occupied, interference, distress, resistance, and degree of control. The OCI-R is an 18-item self-report questionnaire based on the earlier 84-item OCI. Participants rate the degree to which they are bothered or distressed by specific OCD symptoms in the past month.

Besides the FOCI and OCI-R, a number of other widely used self-report instruments exist. The Yale-Brown Obsessive- Compulsive Scale—Self Report concurrently measures the presence and severity of commonly reported symptoms. The Leyton Obsessional Inventory Short Form is a 30-item self-report measure appropriate for children and adults. The presence of common symptoms is answered on a yes/no scale. The Maudsley Obsessional Compulsive Inventory contains 30 true or false items to assess the presence of common obsessions and compulsions. Finally, the Padua Inventory Revised is a 39- item self-report measure of obsessions and compulsions rated on a five-point scale according to the degree of disturbance.

Other Measures.
To supplement the above measures, other questionnaires are often given. In children, it is very common for parents to rate their child's behavior on questionnaires such as the Child Obsessive Compulsive Impact Scale or the Children's Obsessional Compulsive Inventory. The former assesses the presence and severity of symptoms; the latter queries impairment related to OCD. Questionnaires about family involvement in symptoms, such as the Family Accommodation Scale (FAS), are also commonly given to family members. The FAS assesses how much others accommodated the patient's obsessions and compulsions by providing reassurance or the help necessary for completion of compulsions, decreasing behavioral expectations, modifying family activities or routines, and/or helping the child avoid objects, places, or experiences that may cause him or her distress.

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