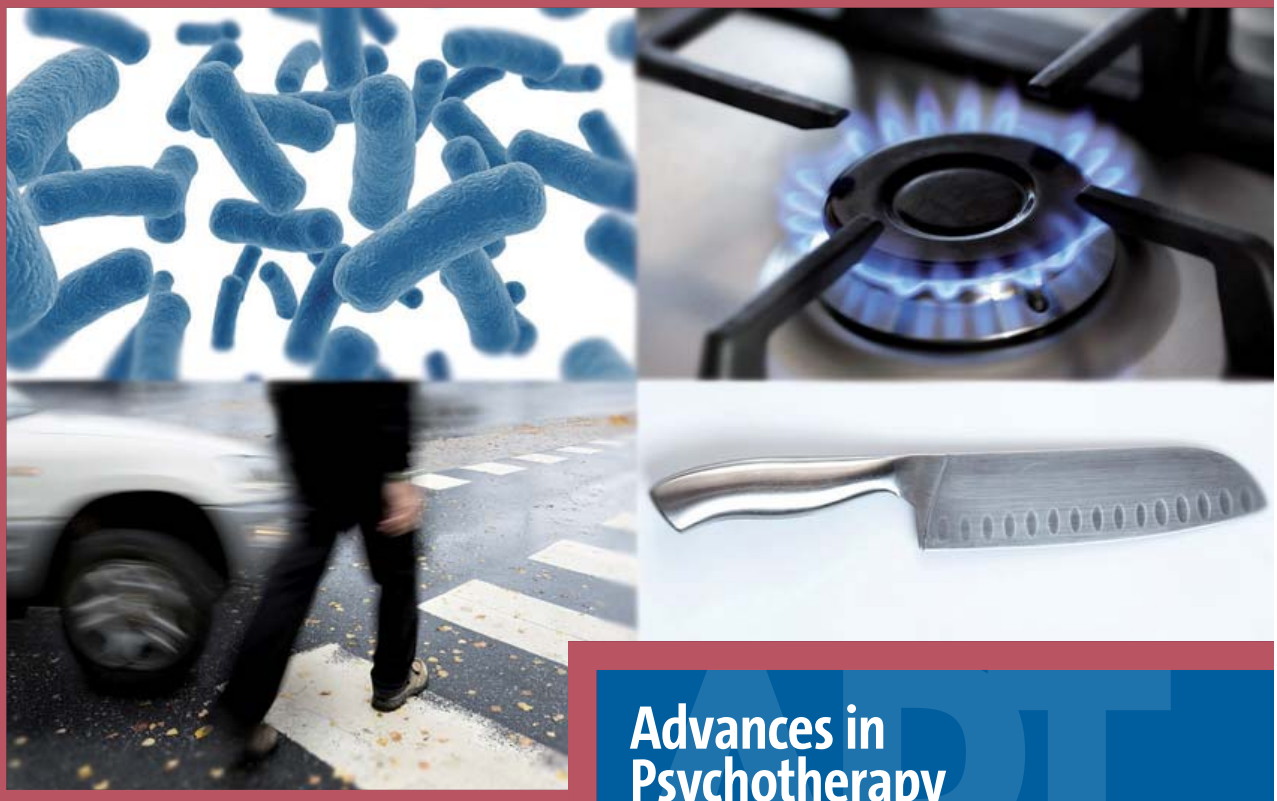
Jonathan S. Abramowitz · Ryan J. Jacoby

Obsessive-Compulsive Disorder in Adults



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Obsessive-Compulsive Disorder in Adults

About the authors

Jonathan S. Abramowitz, PhD, is Professor and Associate Chair of Psychology and Research Professor of Psychiatry at the University of North Carolina (UNC) at Chapel Hill. He is Director of the UNC Anxiety and Stress Disorders Clinic and a North Carolina licensed psychologist with a diplomate from the American Board of Professional Psychology. He is an international expert on anxiety and OCD and has published 12 books and over 200 research articles and book chapters. He is editor of two scientific journals, including the *Journal of Obsessive-Compulsive and Related Disorders*. Dr. Abramowitz has served as President of the Association for Behavioral and Cognitive Therapies.

Ryan Jane Jacoby, MA, is a doctoral student of clinical psychology in the Anxiety/OCD Lab at the University of North Carolina (UNC) at Chapel Hill. She conducts research on the nature and treatment of OCD and anxiety disorders, and is specifically interested in cognitive biases, treatment augmentation strategies, symptom dimensions of OCD, and inhibitory learning approaches to exposure therapy. Ms. Jacoby has published and presented her research at various national and international professional conferences and has received numerous awards for her academic accomplishments.

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Jonathan S. Abramowitz

Ryan J. Jacoby

University of North Carolina at Chapel Hill

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Preface

This book describes the conceptualization, assessment, and psychological treatment of obsessive-compulsive disorder (OCD) in adults using empirically supported cognitive-behavioral (CBT) interventions. The centerpiece of this approach is *exposure and response prevention* (ERP), a well-studied tandem of techniques derived from learning theory accounts of OCD. Recent scientific and clinical advances, however, have led to fine-tuning ERP in ways that can improve its delivery to maximize adherence and outcome. Most notably, the fields of cognitive therapy, acceptance and commitment therapy (ACT), couple therapy, and inhibitory learning have implications for ERP for OCD that we have incorporated into this book. We assume the reader – psychologists, psychiatrists, social workers, students and trainees, and other mental health care practitioners – will have basic knowledge and training in the delivery of psychotherapeutic intervention, yet not necessarily be a specialist in OCD. This book is for clinicians wishing to learn therapeutic strategies for managing OCD effectively in day-to-day clinical practice.

The book is divided into five chapters. The first describes the clinical phenomenon of OCD, differentiating it from other problems with similar characteristics and outlining scientifically based diagnostic and assessment procedures. Chapter 2 reviews leading theoretical approaches to the development and maintenance of OCD, and their treatment implications. In Chapter 3, we present a framework for conducting an initial assessment and for deciding whether a particular patient is a candidate for the treatment program (as discussed in Chapter 4). Methods for explaining the diagnosis of OCD and introducing the treatment program are incorporated. Chapter 4 presents in detailed fashion the nuts and bolts of how to conduct effective CBT for OCD. There are numerous case examples and transcripts of in-session dialogues to illustrate the treatment procedures. The chapter also reviews the scientific evidence for the efficacy of this program and discusses how to identify and surmount a number of common obstacles to successful outcomes. Finally, Chapter 5 includes a series of case examples describing the treatment of various sorts of OCD symptoms (contamination, fears of responsibility for harm, etc.). A variety of forms and patient handouts for use in treatment appear in the book's appendix.

OCD is a highly heterogeneous problem. Some patients experience fears of germs and contamination, while others have recurring unwanted anxiety-evoking ideas of committing heinous acts that they are unlikely to commit (e.g., deliberately running into pedestrians while driving). It is rare to see two individuals with completely overlapping symptoms. Thus, we provide a multicomponent approach that guides the clinician in structuring treatment to meet individual patients' needs. In this book you will find practical clinical information and illustrations along with supporting didactic materials for both you and your patients.

Acknowledgments

We are indebted to a large group of people, including series editor Danny Wedding and Robert Dimbleby of Hogrefe Publishing for their invaluable guidance and suggestions. The pages of this book echo with the clinical wisdom we have acquired through direct and indirect learning from masters of the science and art of psychological theory and intervention, including Joanna Arch, Donald Baucom, David A. Clark, Michelle Craske, Edna Foa, Martin Franklin, Michael Kozak, Jack Rachman, Paul Salkovskis, and Michael Twohig.

We dedicate this book to our patients and research participants who come to our clinic seeking help and, in the face of uncertainty, find the courage to confront their anxieties and give up their compulsive behaviors so that they can achieve a better quality of life. They believe in us, confide in us, challenge us, and educate us.

Dedication

To our parents, Ferne and Leslie Abramowitz; Doug and Jennie Jacoby

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1

Description

1.1 Terminology

Obsessive-compulsive disorder (OCD) (300.3) was previously classified as an anxiety disorder in DSM-IV. In DSM-5 (American Psychiatric Association, 2013), it is the flagship diagnosis of the obsessive-compulsive and related disorders (OCRDs), a category of conditions with putatively overlapping features (see Section 1.5).

1.2 Definition

Definition of obsessions and compulsions

OCD is defined in the DSM-5 by the presence of *obsessions* or *compulsions* (see Table 1). Obsessions are persistent intrusive thoughts, ideas, images, impulses, or doubts that are experienced as unacceptable, senseless, or bizarre and that evoke subjective distress in the form of anxiety or doubt. Although highly specific to the individual, obsessions typically concern the following themes: aggression and violence, responsibility for causing harm (e.g., by mistakes), contamination, sex, religion, the need for exactness or completeness, and serious illnesses (e.g., cancer). Most patients with OCD experience multiple types of obsessions. Examples of common and uncommon obsessions appear in Table 2.

Compulsions are urges to perform behavioral or mental rituals to reduce the anxiety or the perceived probability of harm associated with an obsession. Compulsive rituals are deliberate, yet excessive in relation to, and not realistically connected with, the obsessional fear they are performed to neutralize. As with obsessions, rituals are highly individualized. Examples of behavioral (overt) rituals include repetitious hand washing, checking (e.g., locks, the stove), counting, and repeating routine actions (e.g., going through doorways). Examples of mental rituals include excessive prayer and repeating special phrases or numbers to oneself to neutralize obsessional fear. Table 3 presents examples of some common and uncommon compulsive rituals.

Table 1
DSM-5 Symptoms of OCD

Time-consuming (e.g., 1 hr or more) obsessions or compulsions that cause marked distress and impairment in social, occupational, or other areas of functioning

Obsessions:

Repetitive and persistent thoughts, images, or impulses that: (a) are experienced as intrusive and unwanted, (b) cause anxiety or distress, and (c) are not worries about real-life problems. The person tries to ignore or suppress the thoughts, images, or impulses, or neutralize them with some other thought or action.

Compulsions:

Repetitive behaviors or mental acts that are performed in response to an obsession or according to certain rules. Compulsions are aimed at preventing or reducing distress or preventing feared consequences; yet are clearly excessive or are not linked in a realistic way with the obsession.

Insight: The person might have varying levels of insight into the validity of her or his obsessions and compulsions, ranging from good or fair insight, to poor insight, to no insight. The level of insight might change with time and vary depending on the particular theme of obsessional fears.

Tics: Some people with OCD have tic-like OCD symptoms that are characterized by a distressing sensory (somatic) state such as physical discomfort (e.g., in the neck) which is relieved by motor responses that resemble tics (e.g., stretching, eye blinking).

Table 2
Common and Uncommon Obsessions

Common obsessions

- The idea that one is contaminated from dirt, germs, animals, body fluids, bodily waste, or household chemicals
- Doubts that one is (or may become) responsible for harm, bad luck, or other misfortunes such as fires, burglaries, awful mistakes, and injuries (e.g., car accidents)
- Unacceptable sexual ideas (e.g., molestation)
- Unwanted violent impulses (e.g., to attack a helpless person)
- Unwanted sacrilegious thoughts (e.g., of desecrating a place of worship)
- Need for order, symmetry, and completeness
- Fears of certain numbers (e.g., 13, 666), colors (e.g., red), or words (e.g., murder)

Uncommon obsessions

- Fear of having an abortion without realizing it
- Fear that not being able to remember events means they didn't occur
- Fear that one's mind is contaminated by thoughts of unethical situations
- Fear of contamination from a geographic region.

Table 3
Common and Uncommon Compulsive Rituals

Common rituals
- Washing one's hands 40 times per day or taking multiple (lengthy) showers
- Repeatedly cleaning objects or vacuuming the floor
- Returning several times to check that the door is locked
- Placing items in the "correct" order to achieve "balance"
- Retracing one's steps
- Rereading or rewriting to prevent mistakes
- Calling relatives or "experts" to repeatedly ask for reassurance
- Thinking the word "healthy" to counteract hearing the word "cancer"
- Repeated and excessive confessing of one's "sins"
- Repeating a prayer until it is said perfectly

Uncommon rituals
- Having to touch (with equal force) the right side of one's body after being touched on the left side
- Having to look at certain points in space in a specified way
- Having to mentally rearrange letters in sentences to spell out comforting words

1.2.1 Insight

Individuals vary in terms of their insight into the senselessness of their symptoms

People with OCD show a range of "insight" into the validity of their obsessions and compulsions – some acknowledge that their obsessions are unrealistic, while others are more firmly convinced (approaching delusional intensity) that the symptoms are rational. To accommodate this parameter of OCD, the DSM-5 includes specifiers to denote whether the person has (a) good or fair, (b) poor, or (c) no insight into the senselessness of their OCD symptoms. Often, the degree of insight varies within a person across time, situations, and across types of obsessions. For example, someone might have good insight into the senselessness of her violent obsessional thoughts, yet have poor insight regarding fears of contamination from chemicals.

1.2.2 Tics

DSM-5 also includes a specifier to distinguish between people with OCD with and without tic-like symptoms (or a history of a tic disorder). Whereas in "typical" OCD, obsessions lead to a negative *emotional* (affective) state such as anxiety or fear, "tic-related OCD" is characterized by a distressing *sensory* (somatic) state such as physical discomfort in specific body parts (e.g., face) or a diffuse psychological distress or tension (e.g., "in my head"). This sensory discomfort is relieved by motor responses (e.g., head twitching, eye blinking) that can be difficult to distinguish from tics as observed in Tourette's syndrome.

1.2.3 OCD From an Interpersonal Perspective

OCD commonly has an interpersonal component

The previous description highlights the experience of OCD from an individual perspective. Yet OCD commonly has an interpersonal component that may negatively impact close relationships, such as that with a parent, sibling, spouse, or romantic partner (Abramowitz et al., 2013). This component may be manifested in two ways. First, a partner or spouse (or other close friend or relative) might inadvertently be drawn to "help" or "accommodate" with performing compulsive rituals and avoidance behavior out of the desire to show care or concern for the sufferer (e.g., to help reduce expressions of anxiety). Second, OCD symptoms may lead to arguments and other forms of conflict within the relationships.

Symptom Accommodation

Accommodation occurs when a loved one (a) participates in the patient's rituals (e.g., answers reassurance-seeking questions, performs cleaning and checking behaviors for the patient), (b) helps with avoidance strategies (e.g., avoids places deemed "contaminated" by the patient), or (c) helps to resolve or minimize problems that have resulted from the patient's OCD symptoms (e.g., making excuses for the person's behavior, supplying money for special extra-strength soaps). Accommodation might occur at the request (or *demand*) of the individual with OCD, or it might be voluntary and based on the desire to show care and concern by reducing the OCD sufferer's distress. The following vignette illustrates accommodation:

> Mary had obsessional thoughts of harming her grandchildren and avoided her grandchildren and other stimuli that triggered violent images (e.g., knives, hammers, TV news programs). She insisted that her husband, Norman, refrain from discussing their grandchildren, hanging pictures of them in the house, and having them visit their home. Despite his reluctance, Norman went along with these wishes so that Mary could remain calm and avoid the obsessional thoughts. Norman said that, although it was a sacrifice, accommodating Mary's OCD symptoms was one way he showed her how much he loved and cared for her.

Accommodation can be subtle or overt (and extreme) and is observed in distressed and nondistressed relationships. Even if there is no obvious distress, accommodation creates a relationship "system" that fits with the OCD symptoms to perpetuate the problem. For example, accommodation might decrease a patient's motivation to engage in treatment that would require a great deal of effort and change the status quo. It might also be the chief way in which loved ones have learned to show affection for the OCD sufferer. Not surprisingly, accommodation is related to more severe OCD symptoms and poorer long-term treatment outcome.

Relationship Conflict

Relationships in which one person has OCD are often characterized by interdependency, unassertiveness, and avoidant communication patterns that foster conflict. Typically, OCD symptoms and interpersonal distress influence each other (rather than one exclusively leading to the other). For example, a father's

contentious relationship with his adult daughter with OCD might contribute to anxiety and uncertainty that increases the daughter's obsessional doubting. Her compulsive reassurance seeking and overly cautious behavior might also lead to frequent disagreements and conflicts with her father.

1.3 Epidemiology

OCD has a 1-year prevalence of 1.2% and a lifetime prevalence of 2.3% in the adult population (this is equivalent to about 1 in 40 adults; Ruscio, Stein, Chiu, & Kessler, 2010). The disorder affects women slightly more often than men, and the age of onset, although earlier for males, is around age 19 on average.

Most individuals with OCD suffer for several years before receiving adequate diagnosis and treatment. Factors contributing to the under-recognition of OCD include the failure of patients to disclose symptoms, the failure of professionals to screen for obsessions and compulsions during mental status examinations, and difficulties with differential diagnoses (see Section 1.5).

1.4 Course and Prognosis

OCD generally runs a chronic and deteriorating course

OCD symptoms typically develop gradually. An exception is the abrupt onset sometimes observed following pregnancy. The modal age of onset is 6–15 years in males and 20–29 years in females. Generally, OCD has a low rate of spontaneous remission. Left untreated, the disorder runs a chronic and deteriorating course, although symptoms may wax and wane in severity over time (often dependent upon levels of psychosocial stress).

1.5 Differential Diagnoses

OCD is often confused with other disorders with seemingly similar features

In clinical practice, OCD can be difficult to differentiate from a number of problems with deceptively similar symptom patterns. Moreover, the terms "obsessive" and "compulsive" are often used indiscriminately to refer to phenomena that are not clinical obsessions and compulsions as defined by the DSM-5. This section highlights key differences between the symptoms of OCD and those of several other disorders.

1.5.1 Generalized Anxiety Disorder (GAD)

Anxious apprehension may be present in both OCD and GAD. However, whereas worries in GAD concern real-life problems (e.g., finances, relationships), obsessions in OCD contain senseless or bizarre content that is not about general life problems (e.g., fear of contracting AIDS from walking into a hospital) and often involve imagery. Moreover, the content of worries in

GAD may shift frequently, whereas the content of obsessional fears is generally stable over time.

1.5.2 Depression

OCD and depression both involve repetitive negative thoughts. However, depressive ruminations are generalized pessimistic ideas about the self, world, or future (e.g., "no one likes me") with frequent shifts in content. Unlike obsessions, ruminations are not strongly resisted and they do not elicit avoidance or compulsive rituals. Obsessions can be thoughts, ideas, images, and impulses that involve fears of specific disastrous consequences with infrequent shifts in content.

1.5.3 Tics and Tourette's Syndrome (TS)

Some individuals with OCD experience tic-like symptoms

Both OCD and TS sometimes involve stereotyped or rapid movements. However, tics (as in TS) are spontaneous acts evoked by a sensory urge. They serve to reduce sensory tension rather than as an escape from obsessive fear. By contrast, compulsions in OCD are deliberate acts evoked by affective distress and the urge to reduce fear.

1.5.4 Delusional Disorders (e.g., Schizophrenia)

Both OCD and delusional disorders involve bizarre, senseless, and fixed thoughts and beliefs. These thoughts might evoke affective distress in both conditions. However, unlike obsessions, delusions do not lead to compulsive rituals. Schizophrenia is also accompanied by other negative symptoms of thought disorders (e.g., loosening associations) that are not present in OCD.

1.5.5 Impulse Control Problems

Excessive and repetitive behaviors might be present in both OCD and in problems characterized by impulse control difficulties, such as pathological gambling, pathological shopping/buying, hair pulling disorder (aka trichotillomania), kleptomania, skin picking, compulsive Internet use (e.g., viewing pornography), and sexually impulsive behaviors. For this reason, some impulse control problems (i.e., skin picking and hair pulling) are now considered "obsessive-compulsive related disorders" in DSM-5. However, the repetitive behaviors in impulse control problems are typically performed to achieve a feeling of gratification (i.e., they are positively reinforced), whereas compulsive rituals in OCD are performed to escape from distress (i.e., they are negatively reinforced). Although individuals with impulse control problems may experience guilt, shame, and anxiety associated with their problematic behaviors, their anxiety is not triggered by obsessional cues as in OCD. That is, obsessions are not present. Thus, the treatment for these

impulse control problems (i.e., habit reversal training) is very different than CBT for OCD.

1.5.6 Obsessive-Compulsive Personality Disorder (OCPD)

Whereas OCD and OCPD have overlapping names, there are more differences than similarities between the two conditions. OCPD is characterized by rigidity and inflexibility, meticulousness, and sometimes impulsive anger and hostility. People with OCPD often view these traits as functional and therefore consistent with their world view (i.e., they are "ego-syntonic"). On the other hand, OCD symptoms are experienced as upsetting and incongruent with the person's world view (i.e., "ego-dystonic"). Hence, OCD symptoms are resisted, whereas OCPD symptoms are not typically resisted because they do not cause personal distress (although others might become distressed over the person's behaviors).

1.5.7 Illness Anxiety (aka Hypochondriasis)

Persistent thoughts about illnesses and repetitive checking for reassurance can be present in both OCD and illness (or health-related) anxiety (hypochondriasis). In OCD, however, patients evidence additional obsessive themes (e.g., aggression, contamination), whereas in illness anxiety, patients are singly obsessed with their health.

1.5.8 Body Dysmorphic Disorder (BDD)

Both BDD (also an obsessive-compulsive related disorder) and OCD can involve intrusive, distressing thoughts concerning one's appearance. Moreover, repeated checking might be observed in both disorders. However, whereas people with OCD also have other obsessions, the focus of BDD symptoms is limited to one's appearance. In addition, the overall level of insight into the senselessness of BDD symptoms tends to be lower than for OCD.

1.5.9 Hoarding Disorder

Hoarding is classified as its own disorder in DSM-5

Once considered a symptom of OCD, hoarding is now its own diagnostic entity (within the obsessive-compulsive related disorders) in DSM-5. The primary symptoms are excessive acquisition of large quantities of more or less useless objects (e.g., old newspapers and clothes) that cover the living areas of the home, and the inability or unwillingness to discard these objects even though they might impede activities such as cooking, cleaning, moving through the house, and sleeping. Although the collection of objects (and failure to discard them) can appear "compulsive" (and might sometimes be part of OCD-related checking rituals), hoarding behavior is typically not motivated by obsessional fear as in OCD.

1.6 Comorbidities

Comorbidity is common in OCD

The most frequently co-occurring diagnoses among people with OCD are depressive and anxiety disorders. About 50% of people with OCD have experienced at least one major depressive episode (or dysthymia) in their lives. Commonly co-occurring anxiety disorders include generalized anxiety disorder, panic disorder, and social phobia, with rates ranging from 30 to 45% (Crino & Andrews, 1996a). When comorbid depression is present, OCD typically predates the depressive symptoms, suggesting that depressive symptoms usually occur in response to the distress and functional impairment associated with OCD (rather than as a precursor). Depressive symptoms also seem to be more strongly related to the severity of obsessions than to compulsions. Less frequently, individuals with OCD have comorbid eating disorders, tic disorders (e.g., Tourette's syndrome), and impulse control disorders. Studies generally agree that personality disorders belonging to the anxious cluster (e.g., obsessive-compulsive, avoidant) more commonly co-occur with OCD than those of other clusters (Crino & Andrews, 1996b).

1.7 Diagnostic Procedures and Documentation

This section reviews the empirically established structured and semi-structured diagnostic interviews and self-report measures for assessing the presence and severity of OCD symptoms, as well as for documenting changes in these symptoms during a course of psychological treatment.

1.7.1 Structured Diagnostic Interviews

Two structured diagnostic interviews that are based on DSM-IV-TR criteria can be used to confirm the diagnosis of DSM-5 OCD (since very little changed with respect to the diagnostic criteria): the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Di Nardo, Brown, & Barlow, 1994) and the Structured Clinical Interview for DSM-IV (SCID-IV; First, Spitzer, Gibbon, & Williams, 2002). Both of these instruments possess good reliability and validity. The SCID is available over the Internet at http://www.scid4.org, and the ADIS is available from Oxford University Press.

1.7.2 Semi-Structured Symptom Interviews

OCD is unique among the psychological disorders in that the form and content of its symptoms can vary widely from one person to the next. In fact, two individuals with OCD might present with completely nonoverlapping symptoms. Such heterogeneity necessitates a thorough assessment of the *topography* of the individual's symptoms: What types of obsessions and compulsions are present and how severe are these symptoms?

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

The Y-BOCS – a measure of OCD symptom severity

The Y-BOCS (Goodman, Price, Rasmussen, Mazure, Delgado et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann et al., 1989), which includes a symptom checklist and a severity rating scale, is ideal for addressing these questions. Between 30 and 60 min might be required to administer this semi-structured interview. A full copy of the measure appears on a Wikipedia page for the Y-BOCS. The first part of the symptom checklist provides definitions and examples of obsessions and compulsions that the clinician reads to the patient. Next, the clinician reviews a comprehensive list of over 50 common obsessions and compulsions and asks the patient whether each symptom is currently present or has occurred in the past. Finally, the most prominent obsessions, compulsions, and OCD-related avoidance behaviors are listed.

One limitation of the Y-BOCS symptom checklist is that it assesses obsessions and compulsions according to *form* rather than *function*. It is therefore up to the clinician to inquire about the relationship between obsessions and compulsions (i.e., which obsessional thoughts evoke which rituals). A second limitation is that the checklist contains only one item assessing mental rituals. Thus, the clinician must probe in a less structured way for the presence of these covert symptoms. The assessment of mental rituals is discussed further in Section 4.1.1.

The Y-BOCS Severity Scale includes ten items to assess the following five parameters of obsessions (items 1–5) and compulsions (items 6–10): (a) time, (b) interference, (c) distress, (d) efforts to resist, and (e) perceived control. Each item is rated on a scale from 0 to 4, and the item scores are summed to produce a total score ranging from 0 (no symptoms) to 40 (extreme). Table 4 shows the clinical breakdown of scores on the Y-BOCS severity scale. The measure has acceptable reliability, validity, and sensitivity to change. An advantage of the Y-BOCS is that it assesses OCD symptom severity independent of symptom content. However, a drawback of this approach is that the clinician must be cautious to avoid rating the symptoms of other problems (e.g., GAD, impulse control problems) as obsessions or compulsions.

Table 4
Clinical Breakdown of Scores on the Y-BOCS Severity Scale

Y-BOCS score	Clinical severity
0–7	Subclinical
8–15	Mild
16–23	Moderate
24–31	Severe
32–40	Extreme

Brown Assessment of Beliefs Scale (BABS)

The BABS – a measure of insight in OCD

Since poor insight has been linked to attenuated treatment outcome, the assessment of OCD should include determination of the extent to which the patient perceives his or her obsessions and compulsions as senseless and excessive.

The BABS (Eisen et al., 1998) is a semi-structured interview that contains seven items and assesses insight as a continuous variable. The patient first identifies one or two current obsessional fears (e.g., "If I touch dirty laundry without washing my hands, I will become sick"). Next, individual items assess (a) conviction in this belief, (b) perceptions of how others view this belief, (c) explanation for why others hold a different view, (d) willingness to challenge the belief, (e) attempts to disprove the belief, (f) insight into the senselessness of the belief, and (g) ideas/delusions of reference. Each item is rated on a scale from 0 to 4, and the first six items are summed to obtain a total score of 0 to 24 (higher scores indicate poorer insight). The seventh item is not included in the total score. The BABS has good reliability, validity, and sensitivity to change. It is available on the Internet at: http://www.veale.co.uk/wp-content/uploads/2010/11/BABS_revised_501.pdf.

1.7.3 Self-Report Inventories

Self-report inventories are used to gather additional severity data

Psychometrically validated self-report questionnaires can be used to supplement the clinical interviews described above. Such questionnaires are easily administered, carefully worded, and have well-established norms. Accordingly, they are best used to corroborate information obtained from clinical interviewing and to monitor symptom severity during treatment.

Dimensional Obsessive-Compulsive Scale (DOCS)

The DOCS – a brief measure of OCD severity

The DOCS is a 20-item self-report measure that assesses the severity of the four most consistently identified OCD symptom dimensions, which correspond to the measure's four subscales: (a) contamination, (b) responsibility for harm and mistakes, (c) symmetry/ordering/incompleteness, and (d) unacceptable/taboo obsessions. Each subscale begins with a description of the symptom dimension along with examples of representative obsessions and rituals. The examples clarify the form and function of each dimension's fundamental obsessional fears, compulsive rituals, and avoidance behaviors. Each subscale contains five items (rated 0 to 4) to assess the following parameters of severity: (a) time occupied by obsessions and rituals, (b) avoidance behavior, (c) associated distress, (d) functional interference, and (e) difficulty disregarding the obsessions and refraining from the compulsions. Scores for each subscale (symptom dimension) range from 0 (minimum) to 20 (maximum). The DOCS subscales have excellent reliability, and validity, and sensitivity to treatment effects (Abramowitz et al., 2010). Total scores of at least 18 and 21 can help distinguish people with OCD from those with no disorder and an anxiety disorder, respectively. The DOCS is freely available on the Internet at http://www.jabramowitz.com/resources-and-free-stuff.html.

1.7.4 Documenting Changes in Symptom Levels

Assessing OCD symptoms throughout treatment

Continual assessment of OCD and related symptoms throughout the course of psychological treatment assists the clinician in evaluating treatment response. It is not enough to simply assume that "he seems to be less obsessed," or "it

looks like she has cut down on her compulsions," or even for the patient to report that he or she now "feels better." We recommend periodic assessment and comparison with baseline symptom levels using psychometrically validated self-report and interview measures to clarify objectively in what ways treatment has been helpful and what work remains to be done.

2

Theories and Models

A number of theories have been proposed to explain the development and clinical picture of OCD. This chapter reviews several theoretical models that have been well-studied, with an emphasis on the cognitive-behavioral model which forms the basis of the treatment program described in Chapter 4.

2.1 Biological Theories

2.1.1 Neurotransmitter Theories

Biological theories of OCD

Biological models of OCD can be categorized into neurotransmitter and neuroanatomical theories. Prevailing neurotransmitter theories propose that abnormalities in the serotonin system, particularly the hypersensitivity of postsynaptic serotonergic receptors, underlie OCD symptoms. This "serotonin hypothesis" was proposed following observations that serotonergic medication, but not other kinds of antidepressants, were effective in reducing OCD symptoms. However, results from numerous studies that have directly examined the relationship between serotonin and OCD have been inconsistent. For instance, some studies report increased concentrations of serotonin metabolites in the cerebrospinal fluid of OCD patients relative to nonpatients; other studies do not report such findings. Whereas the preferential response of OCD to serotonergic medication is often championed as supporting the serotonin hypothesis, this argument is of little value since the hypothesis was derived from this treatment outcome result. To date there are few convincing data to suggest that problems with serotonin functioning (or other neurotransmitters) mediate OCD symptoms.

2.1.2 Neuroanatomical Theories

Predominant neuroanatomical models of OCD propose that obsessions and compulsions arise from structural and functional abnormalities in particular areas of the brain, specifically the orbitofrontal-subcortical circuits. These circuits are thought to connect regions of the brain involved in processing information with those involved in the initiation of certain behavioral responses; and their over activity is thought to lead to OCD. Neuroanatomic models have been derived from imaging studies in which activity levels in specific parts