**Obsessive-Compulsive Disorder**

**Assessment**

OCD symptoms can be assessed with either clinical interviews or self-report measures. The semi-structured Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al, 1989) is considered the gold standard in OCD assessment. It involves both a symptom checklist that assesses the presence of 40 obsessions and 29 compulsions, and a measure of symptom severity. The total score runs from 0 to 40, with the average patient in most studies ranging between a 24 and 28, and a clinical cut-off score of 14.

There are several self-report instruments:

- Maudsley Obsessive-Compulsive Inventory (Hodgson & Rachman, 1977)
- Padua Inventory – Washington State University Revision (Burns, Keortge, Formea, & Sternberger, 1996)
- Obsessive-Compulsive Inventory – Revised (OCI-R; Foa, Huppert, et al., 2002)

The OCI-R is an 18-item self-report measure that assesses the distress associated with obsessions and compulsions. In addition to the total score, separate subscale scores can be calculated. Excellent psychometric properties have been reported in clinical patients and in a nonclinical sample (Hajcak, Huppert, Simons, & Foa, 2004).

**Treatment**

Behavior therapy that involves both exposure and response prevention are considered the first-line treatment for OCD by experts (Greist et al., 2003). This involves exposing patients to feared stimuli in a hierarchical fashion, and having patients completely refrain from ritualizing. Exposures can be in vivo and/or imaginal. The latter is typically recommended to confront patients with their unrealistic feared catastrophes that cannot and/or should not be produced in reality. During the course of treatment, patients learn that they do not need to ritualize to reduce their anxiety – anxiety habituates on its own. They learn that the feared disasters they anticipate do not materialize and therefore they do not need to protect themselves by ritualizing or avoiding feared situations.

Several studies have shown exposure and response prevention to be superior to a number of controlled treatments (Abramowitz, 1997). Many studies have demonstrated sustained treatment gains for up to five years (Marks, 1997). There is support for the general effectiveness in both nonresearch and private practice settings (Franklin, Abromawitz, Kozak, Levitt, & Foa, 2000), as well as in ethnically diverse populations (Friedman et al., 2003).

Many studies have found that psychopharmacological treatment with SSRIs results in significantly greater OCD symptom reduction relative to placebo (Dougherty, Rauch, & Jenike, 2002). Relapse rates, however, have been found to be high (Koran et al., 2002). Longer-term treatment may reduce rates of relapse somewhat (Hollander et al., 2003). Deep brain stimulation...
(Kopell, Greenberg, & Rezai, 2004) and the surgical removal of the cingulate have shown to improve some treatment-resistant cases (Dougherty et al., 2002).

A number of factors appear related to poor outcome following therapy:

- Specific patterns of pretreatment brain activity (Hurley, Saxena, Rauch, Hoehn-Saric, & Taber, 2002)
- Patients that have obsessions in the absence of overt rituals may fare more poorly than patients with overt rituals (Rachman & Hodgson, 1980).
- Poor insight is associated with poorer outcome (Abramowitz et al., 2003)
- Hoarding is related to poorer outcome following both cognitive-behavioral therapy and pharmacotherapy (Abramowitz et al., 2000; Mataix-Cols, Rauch, Manxo, Jenike, & Baer, 1999).
- Severe depression may also be associated with a somewhat attenuated treatment response (Abramowitz et al., 2000)

**Helpful Resources**

- [www.adaa.org/AnxietyDisorderInfor/OCD.cfm](http://www.adaa.org/AnxietyDisorderInfor/OCD.cfm)
- [www.ocfoundation.org](http://www.ocfoundation.org)
- [www.med.upenn.edu/ctsa](http://www.med.upenn.edu/ctsa)
- [www.nimh.nih.gov/HealthInformation/ocdmenu.cfm](http://www.nimh.nih.gov/HealthInformation/ocdmenu.cfm)


