Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

SELENI

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

INSTRUCTION MANUAL
Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures

BACKGROUND

The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders.[1] Patients first completed a one-page 27-item screener and, for those disorders for which they screened positive, were asked additional questions by the clinician using a structured interview guide. However, this 2-stage process took an average of 5-6 minutes of clinician time in patients without a mental disorder diagnosis and 11-12 minutes in patients with a diagnosis. This proved to be a barrier to use given the competing demands in busy clinical practice settings.

Therefore, in two large studies enrolling 6000 patients (3000 from general internal medicine and family practice clinics and 3000 from obstetrics-gynecology clinics), a self-administered version of the PRIME-MD called the Patient Health Questionnaire (PHQ) was developed and validated.[2,3] In the past decade, the PHQ in general and the PHQ-9 depression scale in particular [4-6] have gained increasing use in both research and practice. The original PRIME-MD is now largely of historical interest and seldom used except in a few types of research studies.

Given the popularity of the PHQ-9 for assessing and monitoring depression severity, a new 7-item anxiety scale using a response set similar to the PHQ-9 was initially developed to diagnose generalized anxiety disorder (hence its name, the GAD-7) and validated in 2740 primary care patients.[7] Though originally developed to diagnose generalized anxiety disorder, the GAD-7 also proved to have good sensitivity and specificity as a screener for panic, social anxiety, and post-traumatic stress disorder.[8] Finally, the PHQ-15 was derived from the original PHQ studies and is increasingly used to assess somatic symptom severity and the potential presence of somatization and somatoform disorders.[9]

Each PHQ module can be used alone (e.g. the PHQ-9 if depression is the condition of interest), together with other modules, or as part of the full PHQ. Also, alternative or abbreviated versions of the PHQ-9 and GAD-7 are sometimes used in certain screening or research settings [10-14]
Although the PHQ was originally developed to detect five disorders, the depression, anxiety, and somatoform modules (in that order) have turned out to be the most popular.[10] Also, most primary care patients with depressive or anxiety disorders present with somatic complaints and co-occurrence of somatic, anxiety, and depressive symptoms (the *SAD* triad) is exceptionally common. This is the rationale behind the PHQ-SADS screener.[15] The most commonly used versions of the PHQ scales are summarized in **Table 1, page 3**.

CODING AND SCORING

The full PHQ, Brief PHQ, and PHQ for Adolescents (PHQ-A) can be used to establish provisional diagnoses for selected DSM-IV disorders. The diagnostic algorithm for the PHQ modules are included in footers at the bottom of each page of the PHQ, and also reiterated in **Table 2, page 4**. The other measures are principally used to derive severity scores (PHQ-9 and PHQ-8 for depressive symptom severity; GAD-7 for anxiety symptom severity; PHQ-15 for somatic symptom severity) or as ultra-brief screeners (PHQ-2, GAD-2, PHQ-4). An example in which the PHQ depression module can be used as both a diagnostic module as well as a depression severity score (PHQ-9 score) is shown in **Table 3, page 5.**

Over time, the severity scores have been a particularly popular use of the measures, and are now used much more commonly than the provisional diagnoses. For example, cutpoints of 5, 10, and 15 represent mild, moderate, and severe levels of depressive, anxiety, and somatic symptoms, on the PHQ-9, GAD-7, and PHQ-15 respectively. Also, a cutpoint of 10 or greater is considered a “yellow flag” on all 3 measures (i.e., drawing attention to a possible clinically significant condition), while a cutpoint of 15 is a “red flag” on all 3 measures (i.e., targeting individuals in whom active treatment is probably warranted). For the ultra-brief measures (PHQ-2 and GAD-2), a score of 3 or greater should prompt administration of the full PHQ-9 and/or GAD-7, as well as a clinical interview to determine whether a mental disorder is present.

The final question on the PHQ (and some of its abbreviated versions) asks the patients to report “how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?” This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient’s global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

A particularly important question is how to assess suicide risk in individuals who answer positively to the 9th question of the PHQ-9. A four-item screener has been developed that may assist in positive responses to this 9th question [16], although a final decision about the actual risk of self-harm requires a clinical interview.

Table 1. Versions: Patient Health Questionnaire (PHQ) Family of Measures

Measure	Description	Scoring	References
Core			
PRIME-MD	Predecessor of PHQ, now mainly of historical interest.	Combined self-administered patient screener with clinician follow-up questions.	1
PHQ	Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.	Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.	2, 3
PHQ-9	Depression scale from PHQ.	Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.	1, 4, 5, 6, 10
GAD-7	Anxiety measure developed after PHQ but incorporated into PHQ-SADS.	Seven items, each of which is scored 0 to 3, providing a 0 to 21 severity score.	7, 8, 10
PHQ-15	Somatic symptom scale from PHQ.	Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.	9, 10
PHQ-SADS	PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ.	See scoring for these scales above.	10
Variants			
Brief PHQ	PHQ-9 and panic measures from original PHQ plus items on stressors and women's health.	See scoring for PHQ above. Stressor and women's health items are not diagnostic or scored.	3
PHQ-A	Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ.	Diagnostic scoring described in manual, available upon request.	11
PHQ-2	First 2 items of PHQ-9. Ultra-brief depression screener.	Two items scored 0 to 3 (total score of 0-6)	10, 12
GAD-2	First 2 items of GAD-7. Ultra-brief anxiety screener.	Two items scored 0 to 3 (total score of 0-6)	8, 10, 12
PHQ-4	PHQ-2 and GAD-2.	See PHQ-2 and GAD-2 above.	10, 12, 13
PHQ-8	All items of PHQ-9 except the 9th item on self-harm. Mainly used in non-depression research studies.	Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.	5, 10, 14

Table 2. Diagnostic Algorithms for the PHQ

Page 1

Somatoform Disorder if at least 3 of #1a-m bother the patient "a lot" and lack an adequate biological explanation.

Major Depressive Syndrome if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) .

Other Depressive Syndrome if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Note**:** the diagnoses of Major Depressive Disorder and Other Depressive Disorder requires ruling out normal *bereavement (mild symptoms, duration less than 2 months***)**, a history of a *manic* episode (Bipolar Disorder) and a *physical disorder, medication or other drug* as the biological cause of the depressive symptoms.

Page 2

Panic Syndrome if #3a-d are all 'YES' and 4 or more of #4a-k are 'YES'.

Other Anxiety Syndrome if #5a and answers to three or more of #5b-g are "More than half the days".

Note**:** The diagnoses of Panic Disorder and Other Anxiety Disorder require ruling out a *physical disorder***,** *medication or other drug* as the biological cause of the anxiety symptoms.

Page 3

Bulimia Nervosa if #6a,b, and c and #8 are 'YES';

Binge Eating Disorder the same but #8 is either 'NO' or left blank.

Alcohol abuse if any of #10a-e are "YES".

Additional Clinical Considerations. After making a provisional diagnosis with the PHQ, there are additional clinical considerations that may affect decisions about management and treatment.

- *Have current symptoms been triggered by psychosocial **stressor(s**)?*
- *What is the **duration** of the current disturbance and has the patient received any **treatment** for it?*
- *To what extent are the patient's symptoms i**mpairing** his or her usual work and activities?*
- *Is there a **history** of similar episodes, and were they **treated**?*
- *Is there a **family history** of similar conditions?*

Table 3. Example of PHQ Depression Module for both Diagnostic and Severity Purposes

Patient: A 43-year-old woman who looks sad and complains of fatigue for the past month.

2. Over the last 2 weeks, how often have you been bothered by any of the following:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	(0)	(1)	(2)	(3)
a. Little interest or pleasure in doing things?……..	☐	☐	☐	☒
b. Feeling down, depressed, or hopeless?……..…	☐	☒	☐	☐
c. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☒	☐
d. Feeling tired or having little energy?.....……...…..	☐	☐	☐	☒
e. Poor appetite or overeating?.....…….….	☐	☒	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?……..	☐	☐	☒	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television? ……..	☐	☐	☐	☒
h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?.....……..	☒	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way? …….	☐	☒	☐	☐

FOR OFFICE CODING: Maj Dep Syn if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) . Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Major Depressive Disorder Diagnosis. The criteria for Major Depressive Syndrome are met since she checked #2a "nearly every day" and five of items #2a to i were checked "more than half the days" or "nearly every day". Note that #2i, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis of Major Depressive Disorder (not Syndrome) was made since questioning by the physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case, the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

USE OF SOME SCREENERS AS SEVERITY AND OUTCOME MEASURES

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case (see table 3, page 5), the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed. The **PHQ-8** is scored just like the PHQ-9 and its total score ranges from 0 to 24. Cutpoints on the PHQ-8 are identical to the PHQ-9.

GAD-7 Anxiety Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutpoints for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for anxiety disorders, a recommended cutpoint for further evaluation is a score of 10 or greater.

PHQ-2 and GAD-2 Severity. These consist of the first two items of the PHQ-9 and GAD-7 respectively, and constitute the two core DSM-IV items for major depressive disorder and generalized anxiety disorder, respectively. Each ranges from a score of 0 to 6. The operating characteristics of these ultra-brief measures are quite good; the recommended cutpoints for each when used as screeners is a score of 3 or greater. When used together, they are referred to as the **PHQ-4** a 4-item screening measure which ranges from a score of 0 to 12, and serves as a good measure of "caseness" (i.e., the higher the score, the more likely there is an underlying depressive or anxiety disorder). In particular, the PHQ-2 and GAD-2 subscores of the PHQ-4 provide separate depressive and anxiety scores, and can be used as screeners for depression and anxiety.

PHQ-15 Somatic Symptom Severity. This is calculated by assigning scores of 0, 1, and 2 to the response categories of "not at all", "bothered a little", and "bothered a lot", for the 13 somatic symptoms of the PHQ (items 1a-1m). Also, 2 items from the depression module (sleep and tired) are scored 0 ("not at all"), 1 ("several days") or 2 ("more than half the days" or "nearly every day"). Thus, a PHQ-15 score can be derived from page 1 of the PHQ, or from separate administration of the PHQ-15 scale or the PHQ-SADS. PHQ-15 scores of 5, 10, and 15 represent cutpoints for low, medium, and high somatic symptom severity, respectively.

Sensitivity to Change for Monitoring Treatment Outcomes. A particularly important use of a measure is its responsiveness to changes of condition severity over time. This is well-established for the PHQ-9 which is increasingly used as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response).[6,10] An example of how different PHQ-9 severity levels might guide treatment is shown in **Table 4, page 7**. There is preliminary evidence that the PHQ-15 may be responsive to changes as individuals with somatoform disorders or high somatization are treated.[10] The GAD-7 has demonstrated change as a secondary anxiety outcome in several depression trials, but has not yet been studied as a primary outcome in anxiety trials. Also, since there is more diagnostic splitting for anxiety than for depressive disorders, it remains to be determined whether a single anxiety measure can suffice as an outcome measure. It is likely the GAD-7 will be useful but not yet certain it will be sufficient.

Psychometrics. The psychometrics of the PHQ and its component scales are described in the validation articles for specific measures (see Selected References on page 9) and are summarized in a review article on the PHQ-9, GAD-7, and PHQ-15.[10]

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

TRANSLATIONS

There are numerous translations of the PHQ as well as the PHQ-9 and GAD-7 available in many languages, which are freely downloadable on the PHQ website (www.phqscreeners.com). The abbreviated versions of these measures – PHQ-8, PHQ-2, GAD-2, and PHQ-4 – can simply be derived from the translations by selecting the relevant items (see Table 1, page 3). The PHQ-15 can also be simply derived by selecting the 13 somatic items (1a-1m), plus the *sleep* and *tired* items (2c and 2c) from the PHQ translations.

Many of the translations have been developed by the MAPI Research Institute using an internationally accepted translation methodology. Thus, most of the translations are linguistically valid. However, unlike the English versions of the PHQ and GAD-7, few of the translations have been psychometrically validated against an independent structured psychiatric interview.

WEBSITE

Copies of the PHQ family of measures, including the GAD-7, are available at the website:

www.phqscreeners.com

Also, translations, a bibliography, an instruction manual, and other information is provided on this website.

QUESTIONS REGARDING DEVELOPMENT, ACKNOWLEDGMENTS AND USE

The PHQ family of measures (see Table 1, page 3), including abbreviated and alternative versions as well as the GAD-7, were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

All of the measures included in Table 1 are in the public domain. No permission is required to reproduce, translate, display or distribute.

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Y-BOCS-II

Clinical Version

By the Principal Developers of the Original
Yale-Brown Obsessive Compulsive Scale

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Individuals or organizations interested in using this rating scale should contact Dr. Goodman, Professor and Chairman, PO Box 100256, Gainesville, FL 32610 <wkgood@psychiatry.ufl.edu>.

INTRODUCTION TO THE 2004 REVISION

Since its introduction in 1986, the Y-BOCS has become the gold standard for rating symptom severity in patients with obsessive-compulsive disorder (OCD). Used worldwide, with translations into more than 20 languages, it serves as the primary outcome measure in clinical trials of pharmacological agents as well as in studies of behavior therapy. Despite this broad range of acceptance, nearly two decades of experience has taught us that there's still room for improvement.

This new edition of the Y-BOCS, the Y-BOCS-II, is different from the revised first edition (1989) in several ways. The most important changes are: 1) "resistance against obsessions" (item #4) has been replaced by "obsession-free interval"; 2) the scoring of all items has been expanded from 5-point (0-4) to 6-point (0-5) response scales, so that the upper limit on the total Y-BOCS-II (sum of items 1 –10) is now equal to 50 instead of 40; 3) assessment of avoidance behaviors has been given added emphasis as reflected in the instructions and anchor points for most items; 4) extensive modifications have been made in the content and format of the Symptom Checklist; and 5) fine tuning of wording or format.

1) Item Changes: Item 4 of the original scale ("resistance against obsessions") has been eliminated. In several studies this item had the lowest correlation with the total Y-BOCS score. It was originally included in an effort to create an equal number of analogous items for obsessions and compulsions. When we introduced this item we noted that it did not directly measure the severity of the intrusive thoughts; rather it rated a manifestation of health, i.e., the effort the patient makes to counteract obsessions by means other than avoidance or the performance of compulsions. We hypothesized that the more the patient tried to resist obsessions, the less impaired was this aspect of his/her functioning. Conversely, patients who made less effort to resist (fight) their obsessions were viewed as less healthy or more severely ill. These principles hold for resisting compulsions, but can be a conceptual stretch when assessing obsessions. Applying this item to patients undergoing behavioral therapy proved particularly confusing. Patients in behavioral therapy are encouraged to counteract their obsessive symptoms by not struggling against them (e.g., "just let the thoughts come") or by intentionally bringing on the disturbing thoughts. These techniques are essential ingredients of exposure therapy. Although we asked raters to score these behavioral techniques as forms of "resistance", many patients schooled in behavior therapy found the item difficult to understand, and so it has been abandoned. In contrast to this item for obsessions, its counterpart "resistance against compulsions," has not proved problematic in these respects and so has been retained. Most patients can easily describe how much they resist performing rituals. The item is compatible with behavior therapy that encourages patients to resist their compulsions.

To preserve an equal number of items for purposes of comparing severity of obsessions versus compulsions – as well as to improve sensitivity to change at the high end (vide infra) – we sought to replace the original item 4 with a new item. For a number of years we had been examining whether an item that evaluates the symptom-free interval might be useful. We found that asking patients about how long they were without intrusive thoughts improved assessment of the time-burden imposed by obsessions. The new item 2 ("obsession-free interval") is intended to examine a dimension of symptom severity (duration of symptom-free interval) that complements item 1 (duration of symptoms). During the course of clinical improvement some patients with OCD seem to report lengthening of their symptom-free interval before they report shortening of the total hours occupied by their obsessive-compulsive symptoms. Studies are underway to confirm whether this item enhances the sensitivity of the Y-BOCS-II to change. Another way of viewing this item is as the reciprocal of frequency, a parameter that is no longer directly assessed in the time occupied by obsessions item. A corresponding item for compulsions, i.e., compulsion-free interval, was not adopted after several years of experimentation failed to show any clear advantage of the time occupied by compulsions item alone.

2) Sensitivity to change: Experience with patients suffering from the most extreme cases of OCD has shown us that the Y-BOCS is not sensitive enough to measure small but clinically meaningful differences in symptom

severity. In some of these extremely ill patients we observed modest improvement in response to treatment interventions but were unable to document the change with the Y-BOCS. For example, the old Y-BOCS would not be able to detect if a patient's time spent on obsessions decreased from 16 hours to 8 hours a day, a 50% reduction. To deal with this limitation, the upper ends of all ten items have been expanded so that there are now six response categories to choose from instead of five. In essence, the highest severity rating from of the previous version was split in two with minimal alterations in anchors for the other four choices at lower severity levels. The highest possible total score has been increased from 40 to 50. The majority of patients should continue to fall within the range of the First Edition, with a small yet important minority of patients receiving a score above 40.

3) Avoidance: We have grown to appreciate that avoidance behaviors are a common part of the clinical picture of OCD and that severity of symptoms can be underestimated because avoidance is being practiced instead of compulsions. As a reflection of the increased importance placed on avoidance behavior we have added probes and anchor points for avoidance to two of the compulsion items: #9 Distress If Compulsions (or Avoidance) Prevented and #10 Interference from Compulsions. The instructions to the obsession interference item have been revised to emphasize the impact of avoidance on functioning.

A full discussion of the nosology of avoidance is beyond the scope of this document. Suffice it to say that the terminology is not standardized. For the purposes of this instrument, consider avoidance along a continuum with one end (say on the left) indistinguishable from compulsions (e.g., ritualized avoidance) and the other (say on the right) blurring with personality traits or lifestyle such as living alone and pursuing a fairly isolated existence – which may be consequences but not necessarily symptoms of OCD. Most avoidance behaviors of interest in this rating scale will fall in the middle of this spectrum. The terms we will use for these three forms of avoidance, proceeding from left to right are: 1. active or ritualized; 2. passive or specific; and 3. generalized.

Like compulsions, active avoidance behaviors are undertaken to neutralize or reduce anxiety. They are often employed in lieu of or to prevent triggering more protracted compulsions. Sometimes the connection and overlap with classic compulsions is obvious when the avoidance becomes ritualized, as in the example of someone who charts her course on a road map to be at least 1 mile from a "contaminated" location. Other times identifying intentional acts of avoidance may be more difficult to discern and require careful probing. (The section on avoidance in the Symptom Checklist should help in this regard.) For the purpose of these ratings, active avoidance behaviors should be treated as compulsions. In some items, the clinician is required to judge whether the avoidance behaviors seem to be specific acts that behave as or replace compulsions. More generalized patterns of avoidance that seem to permeate a person's lifestyle are not to be rated with this instrument.

The impact on functioning of passive avoidance is assessed by item #5 (Interference from Obsessions), item #9 (Distress if Compulsions (or Avoidance) Prevented), # 10 (Interference from Compulsions). An example of passive avoidance covered by item #10 is the patient who stops doing the laundry, letting soiled clothes pile up, because "once he starts washing he can't stop." This type of avoidance has been labeled "practical avoidance" by W.A. Hewlett (personal communication, 2004) because the person seems to be making a decision on pragmatic grounds to save time and effort that would be expended by rituals; another term for this might be "specific avoidance."]

4) Symptom Checklist: Some of the symptoms listed in the new version of the Symptom Checklist have been only been formally recognized since the last edition. The new version has 66 examples of obsessive-compulsive symptoms compared to the 75 listed in the First Edition. For the most part, however, the changes reflect rewording of the old items or dividing them into two or more parts. For example, some of the obsessions are now listed with or without feared consequences. These changes reflect the observation that not all obsessive-compulsive behaviors are undertaken to prevent a dreaded event; in some cases, patients cannot

describe what drives their behaviors, but may report a feeling of discomfort or a need to complete tasks until they feel "just right". Accordingly, the Symptom Checklist has been modified to allow for empirical research aimed at understanding the clinical significance of these distinctions. Other changes in the items or in their grouping reflect the findings of several factor analytic studies. Although the Y-BOCS-II is not intended as a diagnostic instrument, the Symptom Checklist is often used as a diagnostic aid. By the time the administration of the Symptom Checklist is complete, the rater is better informed regarding the nature and scope of the patient's symptoms. In most cases, the Symptom Checklist helps confirm and extend a tentative diagnosis of OCD by disclosing a wider range of symptoms than first suspected. Sometimes in the course of administering the Symptom Checklist the rater identifies symptoms that are not truly indicative of OCD. Because the validity of the severity ratings is predicated on accurate identification of the obsessive-compulsive symptoms being rated, it is imperative to attend to differential diagnostic issues. To enhance the reliability of symptom determination, a number of explanations and examples have been added to the body of the Symptom Checklist. Particular attention is given to clarifying key or difficult differential diagnostic points.

For this new version, we dispensed with a priori symptom headings, such as, contamination, aggression, etc. These were a convenience but might have reduced some flexibility in conceptualization of the symptoms by pigeon holing them in these pre-assigned classifications. For those interested in focusing more attention on the categorization of symptoms, a research version of the Y-BOCS-II has been developed that includes endorsement of individual symptoms according to the following thematic categories: a. "anxious" type (harm avoidance/safety); b. "bad" (unwanted disturbing thoughts or impulses involving aggression, sex or religion); c. "completeness" (need for incompleteness and without feared consequences); d. Disgust (contamination concerns without feared consequences, just revulsion); e. Hoarding; and f. Unclassifed. These symptom dimensions were selected based on several factor analytic studies in OCD.

5) Other changes: We have attempted to sharpen distinctions between questions for obsessions and compulsions. For example, interference from compulsions now includes reference to conspicuousness of compulsions as a parameter specific to compulsions. We have shuffled the order of the severity items to minimize differences between the relative position of queries about obsessions and compulsions and moved assessment of interference (functioning) to a more appropriate place: last, after the other domains have been reviewed.

Implications for Psychometric Properties: These changes should not have significant effects on the established psychometric performance of the scale. We expect to see some enhanced sensitivity to change and better agreement between the total score and a new obsession item (i.e., "obsession-free interval") compared to a previous item (i.e., "resistance against obsessions"). Other changes were made to improve performance in special cases, particularly the measurement of small differences in symptom severity in extremely ill patients. For the most part, the individual item score corresponding to 4 (previously the highest point on the severity range) was cleaved into two separate scores of 4 and 5. In contrast, the anchors corresponding to ratings of 0, 1, 2 and 3 were left intact, thus preserving comparability of the two editions of the Y-BOCS at the lower end of the severity range. In essence, the upper end of the scale range has been expanded and subdivided. To preserve the psychometric properties demonstrated in studies of the original version (Goodman WK, Price LH, Rasmussen SA, et al, 1989a; 1989b), the principal probes and anchor points of most questions have not been substantially modified. Expanding the evaluation of avoidance behaviors should provide better coverage of the domain of symptomatic behaviors actually exhibited by patients with OCD. The intention of these changes is to better capture symptom severity for patients who might otherwise score low on compulsions when avoidance is being practiced instead. The new version of the Symptom Checklist should facilitate reliable and broad identification of obsessive-compulsive symptoms; it should also facilitate research into the structure of symptom typology in OCD.

General Instructions

This rating scale is designed to rate the severity and record the types of symptoms in a patient diagnosed with obsessive-compulsive disorder (OCD). In general, the items depend on the patient's report; however, the final rating is based on the clinical judgment of the interviewer. Rate the characteristics of each item during the prior week up until and including the time of the interview. Scores should reflect the average (mean) occurrence of each item for the entire week.

This rating scale is intended for use as a semi-structured interview. The interviewer should assess the items in the listed order and use the questions provided. However, the interviewer is free to ask additional questions for purposes of clarification. If the patient volunteers information at any time during the interview, that information will be considered. Ratings should be based primarily on reports and observations gained during the interview. If you judge that the information being provided is grossly inaccurate, then the reliability of the patient is in doubt and should be noted accordingly at the end of the interview (last item).

Additional information furnished by others (e.g., spouse or parent) may be included in a determination of the ratings only if (1) such information is judged essential to adequately assess symptom severity *and* (2) consistent week-to-week reporting can be ensured by having the same informant(s) present for each rating session.

Before proceeding with the questions, define "obsessions", "compulsions" and “avoidance” for the patient as follows:

> "OBSESSIONS are unwelcome and distressing ideas, thoughts, images or impulses that repeatedly enter your mind. They may seem to occur against your will. They may be repugnant to you, you may recognize them as senseless, and they may not fit your personality or value system."
>
> "An example of an obsession is: the recurrent thought you might be responsible for making a loved one ill because you weren’t careful enough about washing your hands.”
>
> "COMPULSIONS, on the other hand, are behaviors or mental acts that you feel driven to perform although you may recognize them as senseless or excessive. At times, you may try to resist doing them but this may prove difficult. You may experience anxiety that does not diminish until the behavior or mental act is completed. Sometimes compulsions are also referred to as rituals."

[The term "rituals" will be used interchangeably with compulsions, although the former usually connotes particularly rule-governed, rigid, or complex behavior]

> "An example of a compulsion is: the need to repeatedly check appliances, water faucets, and the lock on the front door before you can leave the house. While most compulsions are observable behaviors, some are unobservable mental acts, such as silent checking or having to recite nonsense phrases to yourself each time you have a bad thought. These mental compulsions are different from obsessions, which are unwelcome and senseless ideas that enter your mind against your will. So, you might have a persistent irrational thought that you had done something to endanger someone's life (obsession), which you then try to neutralize by saying over and over again in your mind that you hadn't done anything harmful (mental compulsion)."

> "AVOIDANCE of feared situations is often used in addition to or in place of compulsions in order to prevent contact with triggers to OCD. An example would be to drive no closer than a one mile of a hospital in a person concerned with contracting a serious disease."
>
> "Do you have any questions about what these words mean?" [If not, proceed.]

On repeated testing it is not always necessary to re-read these definitions and examples as long as it can be established that the patient understands them. It may be sufficient to remind the patient that obsessions are the thoughts or concerns and compulsions are the things one feels driven to do, including covert mental acts.

Have the patient enumerate current obsessions and compulsions in order to generate a list of target symptoms. Use the Y-BOCS-II Symptom Checklist as an aid for identifying recent and past symptoms. For the purposes of the initial administration of the Symptom Checklist, "recent" symptoms are defined as having been present in the last 30 days, including the day of the interview. By definition, "past" symptoms are those that appeared more than 30 days prior to the initial assessment. It is useful to identify and be aware of past symptoms as they may re-appear during subsequent rating sessions. Another reason for identifying past symptoms is for research purposes. The lifetime obsessive-compulsive symptom profile may hold valuable information for characterizing possible subtypes of OCD. The term "current" symptoms refers to those present during the time frame being measured by the severity items of the Y-BOCS-II. In most instances, this time frame ranges from one to two weeks, the most common interval between visits in clinical trials. The Y-BOCS-II is designed to measure symptom severity over a time period as short as 24 hours. As there is much overlap between current and recent symptoms, these terms are generally used interchangeably.

Once recent and current types of obsessions and compulsions are identified, organize and list them on the Target Symptoms form according to clinically convenient distinctions (e.g., divide target compulsions into checking and washing). Describe salient features of the symptoms so that they can be more easily tracked (e.g., in addition to listing checking, specify what the patient checks for). Be sure to indicate which are the most prominent symptoms, i.e., those that will be the major focus of assessment. Note, however, that the final score for each item should reflect a composite rating of all of the patient's obsessions or compulsions.

The rater must ascertain whether reported behaviors are bona fide symptoms of OCD and not symptoms of another disorder, such as specific phobia or a paraphilia. It is important to ascertain that, when active avoidance is rated on items 6-10, the avoidant behavior is related to the obsessions and compulsions and not to some other anxiety-related symptoms. This may be difficult when the patient has comorbid anxiety disorders that involve avoidance. For example, an OCD patient with sexual and aggressive thoughts may have comorbid social phobia. It would be appropriate to rate avoidance secondary to the obsessive thoughts, but not avoidance secondary to the social phobia. The differential diagnosis between certain complex motor tics and certain compulsions (e.g., those involving touching) may be difficult or impossible. In such cases, it is particularly important to provide explicit descriptions of the target symptoms and to be consistent in subsequent ratings. Separate assessment of tic severity with a tic rating instrument may be necessary in such cases. Some of the items listed on the Y-BOCS-II Symptom Checklist, such as trichotillomania, are currently classified in DSM-IV as symptoms of an impulse control disorder. When using the Y-BOCS-II to rate the severity of symptoms not strictly classified under OCD (e.g., hair pulling in trichotillomania) in a patient who otherwise meets criteria for OCD, it has been our practice to administer the Y-BOCS-II twice: once for conventional obsessive-compulsive symptoms and a second time for putative OCD-related phenomena. In this fashion separate Y-BOCS-II scores are generated for severity of OCD symptoms and severity of other symptoms in which the relationship to OCD is still not established. Similarly, separate Y-BOCS-II scores can be generated for individual types of obsessive-compulsive symptoms as identified in the Checklist or captured on the Target List. With each iteration of the scale, the time of administration is increased, making it impractical to track the severity of

multiple individual symptom clusters for most clinical purposes. The symptom-specific or "dimensional" approach to assessing symptom severity should be reserved for specialized research applications.

On repeated testing, review and, if necessary, revise target obsessions prior to rating item 1. Do likewise for compulsions prior to rating item 6.

The total Y-BOCS-II score is the sum of items 1-10, range = 0 (no symptoms) to 50 (extreme symptoms), whereas the obsession and compulsion subtotals are the sums of items 1-5 and 6-10, respectively.

The last two items, 11 and 12, which rate insight and estimate the reliability of the information reported by the patient, respectively, may assist in the interpretation of scores on the Y-BOCS-II. They are not intended as measures of symptom severity.

Additional information regarding the development, use, and psychometric properties of the Y-BOCS can be found in Goodman WK, Price LH, Rasmussen SA, et al.: The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part I. Development, use, and reliability. Arch Gen Psychiatry (46:1006-1011, 1989) and Goodman WK, Price LH, Rasmussen SA, et al.: The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part II. Validity. Arch Gen Psychiatry (46:1012-1016, 1989). Copies of a version of the Y-BOCS modified for use in children, the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) are available from Dr. Goodman on request at <wkgood@psychiatry.ufl.com>.

Name or ID_____

Date _____

Rater _____

Check √ all that apply. Current symptoms are those present in the last 30 days.

Mark the principal obsessions and compulsions by placing a "P" in the margin next to the corresponding items.

Raters must ascertain whether the reported behaviors are bona fide symptoms of OCD, and not symptoms of another disorder such as specific phobia or trichotillomania. OCD symptoms by nature must interfere with psychosocial functioning and should be differentiated from worries or non-impairing fears. Items marked "*" may or may not be OCD phenomena; only endorse items that reflect OCD.

OBSESSIONS

Current	Past	
		01. **Excessive concern with germs.** Examples: AIDS or hepatitis.
		02. **Excessive concern with contaminants or chemicals.** Examples: household cleansers, asbestos, radiation, pesticides and toxic waste.
		03. **Concern will harm others by spreading germs or contaminants.** Examples: transfer germs from one object to another.
		04. **Bothered by bodily waste or fluids.** Examples: urine, feces, saliva or blood.
		05. **Bothered by sticky substances or residues.** Examples: adhesives, chalk dust, or grease.
		06. **Excessive concern with becoming pregnant or of making someone pregnant.** Example: Woman afraid of conception if she swims in public pool.
		07. **Concerned with having an illness or disease.*** It is not always clear where to draw the line between somatic obsessions and the somatic preoccupations of *hypochondriasis . Factors that point to OCD are the presence of compulsions not limited to seeking reassurance.
		08. **Fear of eating certain foods.*** Examples: excessive concern about risks of certain foods or food preparations, afraid will choke, food will change body chemistry. *Distinguish from anorexia nervosa, in which concern is gaining weight.
		09. **Fear might harm self or others because not careful enough.** Examples: parked car rolling down hill, hit a pedestrian because not paying attention, customer gets injured because you gave him wrong materials or information.
		10. **Fear might harm self or others on impulse.*** Examples: physically harming loved ones, stabbing or poisoning dinner guests, driving car into oncoming traffic, pushing stranger in front of a train. *Distinguish from homicidal/suicidal intent.
		11. **Fear of being responsible for terrible events.** Examples: fire, burglary, flooding house, company going bankrupt, pipes freezing.

		12. **Fear of blurting out obscenities or insults.** Examples: shouting blasphemies in church, yelling fire in the movie theatre, writing obscenities in a business letter.
		13. **Fear of doing something else embarrassing or inappropriate.*** Examples: sexual contact, spitting, taking off clothes in public, walking out with unpaid merchandise. *Distinguish from social phobia.
		14. **Violent, horrific or repulsive images.** Examples: intrusive and disturbing images of car crashes or disfigured people. * Distinguish from PTSD.
		15. **Excessive concern with right/wrong or scrupulosity.** Examples: worries about always doing "the right thing", unfounded worries about lying or cheating, didn't say prayers perfectly.
		16. **Concern with sacrilege or blasphemy.** Examples: intrusive unacceptable thoughts or images about God or religion. Concerns about adherence to religious principles exceed those of religious peer group.
		17. **Excessive fears of Satan or demonic possession**. Examples: fears triggered by "Red Devil" paint, sports teams with word devil in them, "666", pentangles.
		18. **Forbidden or improper sexual thoughts or images.*** Examples: unwanted sexual thoughts about family members; images of unacceptable acts. *Distinguish from paraphilias by asking about fantasy life.
		19. **Experiences unwanted sexual impulses.*** Examples: concerned that might "snap" and commit sexual violation. Feels as if hand is moving toward someone's private parts in the absence of arousal. *Distinguish from paraphilias.
		20. **Excessive concerns about sexual orientation or gender identity.** Examples: person repeatedly wonders if s/he is gay even though there is every reason to believes s/he is heterosexual. *Distinguish from realistic issues around sexual or gender identity.
		21. **Need for symmetry or exactness.** Examples: certain things can't be touched or moved, clothes organized in closet alphabetically, bothered if pictures are not straight or canned goods not lined up.
		22. **Perfection in appearance or grooming.** Examples: excessive concern about appearance of clothing, such as wrinkles, lint, loose threads; bothered if hair not parted exactly straight*. Distinguish from OCPD.
		23. **Fear of saying the wrong thing**. Example: patient may appear to have thought blocking because she is reviewing every possible interpretation of what she is about to say
		24. **Excessively bothered by things not sounding "just right."** Examples: readjusting stereo system until it sounds "just right"; asks family members to say things in just the right way, excessively bothered by visual, auditory or somatic sensations of not being 'just right.'
		25. **Need to know or remember.** Examples: needing to remember insignificant things like license plate numbers, bumper stickers, advertising slogans, names of actors.
		26. **Need to hoard or save things.*** Examples: afraid that something valuable might be discarded with recycled newspapers even though all valuables are locked up in the safe. *Distinguish from hobbies and concern with objects of monetary or sentimental value.
		27. **Fear of losing objects, information, or a person.** Examples: otherwise rational man feared "losing" his 5-year old daughter when mailing envelopes; patient concerned that her "essence" would be left behind when getting up from a chair.

		28. **Magical or Superstitious Fears.** Examples: colors with special significance (black connected with death, red associated with blood and injury), black cats, stepping on side walk cracks, lucky and unlucky numbers, getting pregnant from using a swimming pool.
		29. **Intrusive Meaningless Sounds, Words, or Music.** Examples: songs or music with no special significance play over and over in one's mind like a broken

COMPULSIONS

		30. **Excessive or ritualized hygiene.** Examples: washes hands like surgeon scrubbing for the operating room, uses harsh detergents or very hot water; takes long ritualized showers; excessive tooth brushing or toilet routine.
		31. **Cleaning of household items, inanimate objects or pets.** Examples: floors kept so clean you can eat off them; prolonged vacuuming; daily thorough washing of car tires.
		32. **Checking locks, stove, appliances, emergency brake, faucets, etc**. Examples: Checking that the doors are locked, stove is turned off, appliances unplugged.
		33. **Checking that nothing terrible did/will happen**. Examples: makes sure that did not run over a pedestrian or did not leave cabinet open to poisonous substances, etc.
		34. **Checking that did not make mistake**. Examples: homework, counting money, writing.
		35. **Checking tied to somatic obsessions.*** Examples: repeatedly probing groin to see if hernia is present; scrutinizing skin for signs of cancer; excessive exploration of lymph nodes. *Distinguish from hypochondriasis.
		36. **Need to repeat routine activities or boundary crossings.** Examples: going through doorway, crossing state lines; may get stuck trying to enter a building, doing/undoing rituals, taking clothes on/off, relighting cigarette, turning car on/off, in/out chair, up/down stairs, may have to repeat a certain number of times.
		37. **Evening up behaviors.*** Examples: movement on right side up body has to be balanced with same movement on left side; adjusts height of stockings, tension of shoe laces, plucks or cuts hair to achieve symmetry. *Distinguish latter from trichotillomania, in which hair is not pulled for a specific reason.
		38. **Re-reading* or re-writing.** Examples: doubt information that just read, written letters must look perfect. Distinguish from *dyslexia.
		39. **Counting compulsions.** Examples: counting things like ceiling or floor tiles, books in a bookcase, words in a sentence.
		40. **Ritualized Activity of Daily Living routines.** Example: may have to put clothes on in a certain order, can only go to bed after following an elaborate series of steps, brush teeth in a ritualistic manner.
		41. **Excessive religious rituals.** Example: Repeating prayers or passages from the Bible an inordinate number of times.
		42. **Ordering or arranging compulsions.** Example: straightening piles of stationary on a desktop or adjusting books in a bookcase.
		43. **Repeating what someone else has said.*** Example: word, phrase, or sound. *Distinguish from echolalia of Tourette's Syndrome.
		44. **Asking for reassurance**. Example: repeatedly asking spouse that they performed a routine correctly.
		45. **Ritualized eating behaviors.*** Examples: arrange or eat food in particular way or a specific order to avert a feared consequence other than gaining weight, as in *anorexia nervosa.

		46. **Saves or collects useless items**.* Examples: piles up old newspapers, collects useless objects; house can become obstacle course with piles of trash. *Distinguish from hobbies and concern with objects of monetary or sentimental value.
		47. **Picks up objects that most people would pass by**. Examples: shards of broken glass, nails, pieces of paper with writing on them, staples.
		48. **Examines things that leave one's possession**. Examples: sifts through garbage, ritual for washing off dinner plates to separate waste from accidentally lost items; won't throw out used disposable vacuum bags or the cat litter; repeatedly checks wallet or pocket book to make sure nothing was lost, reopens letters before they are mailed.
		49. **Buys many unneeded items.** Examples: buys 20 umbrellas, 100 boxes of moth balls, etc. *May not be symptom of OCD unless behavior is excessive (e.g., wastes a lot of money, or accumulates closets full of unnecessary items.).
		50. **Need to tell, ask or confess things**. Examples: confessing to sins or wrongs that didn't commit; feels must describe every detail so that nothing is left out; repeats the same question in different ways to make sure it was understood.
		51. **Need to do something until it feels "just right."** Examples: adjusts car seat, straightens pictures, arranges papers on desk, doesn't let go of handshake, until feels an internal signal that it's OK. Has no specific feared consequences in mind.
		52. **Need to touch, tap, or rub***. Examples: urge to touch or run finger along surfaces or edges, lightly touches other people; taps a certain number of times; rubs against soft materials. May be difficult to distinguish from complex motor tics of *Tourette's Syndrome.
		53. **Staring or blinking rituals*.** May be difficult to distinguish from motor tics of * Tourette's Syndrome. If patient says has to blink a certain number or times or stare to neutralize an obsession, endorse as compulsions here.
		54. **Superstitious behaviors**. Examples: steps over sidewalk cracks, spits after having an unwanted thought; makes sure sentences never contain 13 words; makes sign of the cross before dialing area code for New Jersey.
		55. **Mental rituals (other than checking or counting).** Examples: silently reciting prayers or nonsense words to neutralize unwanted thoughts.
		56. **Pervasive slowness**. Extensive difficulty in starting, executing, and finishing a wide range of routines tasks. In extreme cases, may be unable to complete tasks without assistance and may become "paralyzed. *Distinguish from psychomotor retardation secondary to depression or a primary movement disorder.
		57. **Ritualized avoidance.** Examples: plans course on roadmap to stay at least 1 mile from chemical factories.
		58. **Active measures to avoid contact with contaminants or other feared objects.** Examples: wears rubber gloves, doesn't shake hands, has one clean and one dirty hand, won't go near anyone who seems to have a cut, won't sit down in a chair that has a red spot (possibly blood).

Avoidance		
		59. **Avoids doing things, going places or being with someone because of obsessions.**
		60. **Avoid contact with contaminated objects or people**.
		61. **Avoid handling sharp or dangerous objects, or operating vehicles or machinery, out of concern might harm others.**
		62. **Avoid contact with people, children or animals because of unwanted impulses.**
		63. **Avoids talking to or writing to others for fear will say or write the wrong thing.**
		64. **Avoids watching TV, listening to radio or reading newspaper to shield from disturbing information.**
		65. **Avoids going shopping out of concern will buy extra items that aren't needed.**
		66. **Avoids doing things, going places, or being with someone that would trigger time consuming or onerous rituals** (e.g., washing, dressing, etc.).
		67. **Avoids reading or writing because it may bring on rituals** (e.g., re-reading, re-writing).

TARGET SYMPTOM LIST

Obsessions:

1.

2.

3.

Compulsions:

1.

2.

3.

Avoidance:

1.

2.

3.

SEVERITY ITEMS

"I am now going to ask several questions about your obsessive thoughts." [Make reference to the patient's specific obsessions.]

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS

   Q: "How much of your time is occupied by obsessive thoughts?" [When obsessions occur as brief, intermittent intrusions, it may be difficult to assess time occupied by them in terms of total hours. In such cases, posing item #2 first may help identify most appropriate response to item #1. Be sure to exclude ruminations and preoccupations that, unlike obsessions, are ego-syntonic and rational – albeit excessive.)]

   0 = None.
   1 = Mild, less than 1 hr/day.
   2 = Moderate, 1 to 3 hrs/day.
   3 = Severe, greater than 3 and up to 8 hrs/day.
   4 = Very severe, greater than 8 and up to 12 hrs/day.
   5 = Extreme, greater than 12 hrs/day, constant or nearly constant intrusions.

2. OBSESSION-FREE INTERVAL

   Q: "On average, what is the longest continuous period (or block) of time in which you are free of obsessive thoughts?" [Only consider time while awake. You can also ask:] "How frequently do the obsessive thoughts occur?"

   0 = No symptoms.
   1 = Long symptom-free interval, more than 8 consecutive hours/day symptom-free.
   2 = Moderately long symptom-free interval, more than 3 and up to 8 consecutive hours/day symptom-free.
   3 = Short symptom-free interval, from 1 to 3 consecutive hours/day symptom-free.
   4 = Very short symptom-free interval, from less than 1 consecutive hour/day to a few minutes symptom-free; freedom from obsessions measured in minutes.
   5 = Extremely short (or no) symptom-free interval, constant to near constant (less than a minute symptom-free); freedom from obsessions measured in seconds. May experience only momentary relief.

3. DEGREE OF CONTROL OVER OBSESSIVE THOUGHTS

   Q: "How much control do you have over your obsessive thoughts? How successful are you in stopping or ignoring them? Can you dismiss them?"

   0 = Complete control.
   1 = Much control, usually able to stop or ignore obsessions.
   2 = Moderate control, often able to stop or ignore obsessions with some effort and concentration.
   3 = Some control, sometimes able to stop or ignore obsessions.
   4 = Minimal or little control, infrequently able to stop or ignore obsessions, can only divert attention with difficulty.
   5 = No control, experienced as completely involuntary, rarely able to even momentarily alter or let go of obsessive thinking.

4. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS

Q: "How much distress do your obsessive thoughts cause you?" [In most cases, distress is equated with anxiety; however, patients may report that their obsessions are "disturbing" or "upsetting" but deny "anxiety." Only rate distress that seems generated by obsessions, not generalized anxiety or anxiety associated with other conditions.]

0 = None.
1 = Mild, slightly disturbing.
2 = Moderate, definitely disturbing but manageable.
3 = Severe, sometimes to frequently the thoughts are highly disturbing and difficult to manage
4 = Very severe, most if not all thoughts are highly disturbing and difficult to manage.
5 = Extreme, overwhelming and disabling distress whenever a thought occurs.

5. INTERFERENCE DUE TO OBSESSIVE THOUGHTS

Q: "How much do your obsessive thoughts interfere with your social, school, or work (role) functioning?" [If currently not working (or attending school), determine how much performance would be affected if patient were employed (or in school).] "Have you been avoiding doing anything, going any place, or being with anyone because of your obsessions?" [Evaluate impact of avoidance on functioning.]

0 = None. No deliberate avoidance.
1 = Mild, slight interference with social or occupational activities, but overall performance not impaired. Minimal avoidance.
2 = Moderate, definite interference with social or occupational performance, but still manageable. Some avoidance.
3 = Severe, causes significant impairment in one or more (but not all) domains (or aspects) of functioning; e.g., OK at work, but social life on hold. Much avoidance, but at least one area of functioning is relatively free from avoidance.
4 = Very severe, causes significant impairment in ALL major areas of functioning. Leads narrowly circumscribed existence.
5 = Extreme, incapacitating. May be housebound

"The next several questions are about your compulsions." [Make reference to the patient's specific symptoms.]

6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS

Q: "How much time do you spend performing compulsive behaviors?" [When rituals involving activities of daily living are chiefly present, ask:] "How much longer than most people does it take to complete routine activities because of your rituals?" [When compulsions occur as brief, intermittent behaviors, it may be difficult to assess time spent performing them in terms of total hours. In such cases, estimate time by determining how frequently they are performed. Consider both the number of times compulsions are performed and how much of the day is affected. When estimating frequency, count separate occurrences of compulsive behaviors, not number of repetitions. In most cases compulsions are observable behaviors (e.g., hand washing or refusing to shake hands), but some compulsions are covert (e.g., silent checking or praying); these mental rituals should be rated as you would overt compulsions. "Active avoidance" (e.g., rule governed behaviors that ensure a minimum "safe" distance from contaminated areas or wearing a glove on one hand to keep it clean) like compulsions, can manifest as discrete behavioral acts, measurable in hours or by frequency, so should be rated on this item. "Passive avoidance", on the other hand, may be difficult to quantify temporally; however, its relationship to compulsions and resultant impact on distress and functioning can be measured on items 9 and 10 respectively.

0 = None.
1 = Mild, spends less than 1 hr/day or occasional performance of compulsive behaviors.

2 = Moderate, spends from 1 to 3 hrs/day or frequent performance of compulsive behaviors.
3 = Severe, spends more than 3 and up to 8 hrs/day or very frequent performance of compulsive behaviors.
4 = Very severe, spends more than 8 and up to 12 hrs/day performing compulsive; majority of waking hours filled by rituals.
5= Extreme, greater than 12 hrs/day performing compulsive behavior, constant or nearly constant performance of rituals.

7. RESISTANCE AGAINST COMPULSIONS

Q: "How much of an effort do you make to resist the compulsions?" [Only rate effort made to resist, not success or failure in actually controlling the compulsions. How much the patient resists the compulsions may or may not correlate with his ability to control them. Note that this item does not directly measure the severity of the compulsions; rather it rates a manifestation of health, i.e., the effort the patient makes to counteract the compulsions. Thus, the more the patient tries to resist, the less impaired is this aspect of his functioning. If the compulsions are minimal, the patient may not feel the need to resist them. In such cases, a rating of "0" should be given.]

0 = Makes an effort to always resist, or symptoms so minimal doesn't need to actively resist.
1 = Tries to resist most of the time.
2 = Makes moderate effort to resist.
3 = Makes some effort to resist.
4 = Yields to almost all compulsions without attempting to control them, but does so with some hesitation.
5 = Completely yields to all compulsions; experienced as almost involuntary.

8. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR

Q: "How strong is the drive to perform the compulsions?" [Pause] "How much control do you have over the behaviors?" [In contrast to the preceding item on resistance, this item directly measures success or failure in controlling compulsions.]

0 = Complete control.
1 = Much control, usually able to resist compulsions.
2 = Moderate control, pressure to perform behavior, but often able to control it.
3 = Some control, strong drive to perform behaviors, sometimes able to control them.
4 = Minimal or little control, infrequently able to stop behaviors, once started, must be carried to completion; can only delay with difficulty.
5 = No control, drive to carry out compulsions experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity.

9. DISTRESS IF COMPULSIVE BEHAVIOR (OR AVOIDANCE) PREVENTED

Q: "How would you feel if prevented from performing your compulsion(s)?" [Pause] "How distressed would you become?" [Rate degree of distress patient would experience if performance of the ritual were prevented or suddenly interrupted without reassurance. Like compulsions, avoidance maneuvers can reduce distress; conversely, forced confrontation with avoided objects can engender distress. Ask similar questions about avoidance:] "How would you feel if you weren't allowed to avoid?" [In most, but not all cases, performing compulsions reduces anxiety. In other cases, the compulsions themselves can be a source of distress when laborious or demanding; they can even be painful as in the case of washing with scalding hot water. In these cases, distress or discomfort produced by the compulsions can be taken into account when rating this item. Apart from these latter instances, this item can be viewed as an indirect measure of how dependent the individual is on compulsions or avoidance to keep distress in check.]

0 = None.
1 = Mild; becomes only slightly anxious if compulsions (or avoidance) prevented.
2 = Moderate; reports that anxiety definitely increases but remains manageable if compulsions (or avoidance) prevented.
3 = Severe; experiences marked anxiety if some compulsions (or avoidance) are prevented.
4 = Very severe; experiences marked anxiety if almost any compulsion (or avoidance) is prevented.
5 = Extreme; overwhelming anxiety from any attempt to delay or modify compulsions (or avoidance).

10. INTERFERENCE DUE TO COMPULSIONS

Q: "How much do your compulsive behaviors interfere with your social, school, or work (or role) functioning?" [If currently not working (or attending school), determine how much performance would be affected if patient were employed (or in school).] "Have you been avoiding doing anything, going any place, or being out of concern you will trigger the compulsions?" [Evaluate impact of avoidance on functioning. An example of avoidance relevant to assessment of compulsions is letting soiled clothes pile up instead of launching into an exhausting and prolonged laundry routine that will defy interruption.]

0 = None. No deliberate avoidance.
1 = Mild, slight interference with social or occupational activities, but overall performance not impaired. Minimal avoidance.
2 = Moderate, definite interference with social or occupational performance, but still manageable. Some avoidance.
3 = Severe, causes significant impairment in one or more (but not all) domains (or aspects) of functioning; e.g., OK at work, but social life on hold. Compulsions are noticeable to careful observers at times. Much avoidance, but at least one area of functioning is relatively free from avoidance.
4 = Very severe, causes significant impairment in ALL domains of functioning, i.e., social, family, and occupational/school performance. Compulsions are very difficult to disguise and are often apparent to others. Leads narrowly circumscribed existence.
5 = Extreme, incapacitating. Abnormal behaviors are virtually impossible to conceal. May be housebound.

[The remaining items refer to both obsessions and compulsions. Responses to these items are not included in total Y-BOCS-II score. In most clinical trials, item 11 (Insight) should only be rated at the baseline and endpoint of the study period, not at each visit.]

11. INSIGHT INTO OBSESSIONS AND COMPULSIONS

Q: "Do you think your concerns or behaviors are reasonable?" [Pause] "What do you think would happen if you did not perform the compulsion(s)? Are you convinced something would really happen?" [Rate patient's insight into the senselessness or excessiveness of his obsession(s) based on beliefs expressed at the time of the interview.]

0 = Excellent insight, fully rational
1 = Good insight. Readily acknowledges absurdity or excessiveness of thoughts or behaviors but does not seem completely convinced that there isn't something besides anxiety to be concerned about (i.e., has lingering doubts).
2 = Fair insight. Reluctantly admits thoughts or behavior seem unreasonable or excessive, but wavers. May have some unrealistic fears, but no fixed convictions.
3 = Poor insight. Maintains that thoughts or behaviors are not unreasonable or excessive, but acknowledges validity of contrary evidence (i.e., overvalued ideas present).

4 = Lacks insight, delusional. Definitely convinced that concerns and behavior are reasonable, unresponsive to contrary evidence.

12. RELIABILITY: Rate the overall reliability of the rating scores obtained. Factors that may affect reliability include the patient's cooperativeness and his/her natural ability to communicate. The type and severity of obsessive-compulsive symptoms present may interfere with the patient's concentration, attention, or freedom to speak spontaneously (e.g., the content of some obsessions may cause the patient to choose his words very carefully).

0 = Excellent, no reason to suspect data unreliable
1 = Good, factor(s) present that may adversely affect reliability
2 = Fair, factor(s) present that definitely reduce reliability
3 = Poor, very low reliability

[Items 13 and 14 refer to global illness severity. The rater is required to consider global function, not just the severity of obsessive-compulsive symptoms.]

13. GLOBAL SEVERITY: Interviewer's judgment of the overall severity of the patient's illness. Rated from 0 (no illness) to 6 (most severe patient seen). [Consider the degree of distress reported by the patient, the symptoms observed, and the functional impairment reported. Your judgment is required both in averaging this data as well as weighing the reliability or accuracy of the data obtained and should be based on information obtained during the interview.]

0 = No illness
1 = Illness slight, doubtful, transient; no functional impairment
2 = Mild symptoms, little functional impairment
3 = Moderate symptoms, functions with effort
4 = Moderate - Severe symptoms, limited functioning
5 = Severe symptoms, functions mainly with assistance
6 = Extremely Severe symptoms, completely nonfunctional

14. GLOBAL IMPROVEMENT: Rate total overall improvement present SINCE THE INITIAL RATING whether or not, in your judgment, it is due to treatment effects.

0 = Very much worse
1 = Much worse
2 = Minimally worse
3 = No change
4 = Minimally improved
5 = Much improved
6 = Very much improved

Items 13 and 14 are adapted from the Clinical Global Impression Scale (Guy W: ECDEU Assessment Manual for Psychopharmacology: Publication 76-338. Washington, D.C., U.S. Department of Health, Education, and Welfare (1976)).

Additional information regarding the development, use, and psychometric properties of the original Y-BOCS can be found in Goodman WK, Price LH, Rasmussen SA, et al.: The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part I. Development, use, and reliability. Arch Gen Psychiatry (46:1006-1011, 1989). and Goodman WK, Price LH, Rasmussen SA, et al.: The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part II. Validity. Arch Gen Psychiatry (46:1012-1016, 1989).

Copies of a version of the Y-BOCS modified for use in children, the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) (Goodman WK, Rasmussen SA, Price LH, Mazure C, Rapoport JL, Heninger GR, Charney DS), is available from Dr. Goodman upon request.

Yale-Brown Obsessive Compulsive Scale - II

Y-BOCS-II Total

Add items 1 to 10

PATIENT NAME_____ DATE_____

PATIENT ID_____ RATER_____

	None	Mild	Moderate	Severe	Very Severe	Extreme
1. TIME SPENT ON OBSESSIONS	0	1 (<1hr)	2 (1-3 hrs)	3 (3-8 hrs)	4 (8-12 hrs)	5 (12 h - constant)

	Uninterrupted	Long	Moderate	Short	Very Short	None
2. OBSESSION-FREE INTERVAL	0 (No symptoms)	1 (>8 hrs)	2 (3-8 hrs)	3 (1-3 hrs)	4 (minutes to <1 hr)	5 (constant)

	Complete control	Much control	Moderate control	Some control	Minimal control	No control
3. CONTROL OVER OBSESSIONS	0	1	2	3	4	5

	None	Mild	Moderate	Severe	Very Severe	Extreme
4. DISTRESS OF OBSESSIONS	0	1 (slightly disturbing)	2 (disturbing still manageable)	3 (some difficult to manage & highly disturbing)	4 (most difficult to manage & highly disturbing)	5 (overwhelming)

	None	Mild	Moderate	Severe	Very Severe	Extreme
5. INTERFERENCE FROM OBSESSIONS*	0	1 (slight)	2 (definite interference still manageable)	3 (substantial in one or more areas)	4 (substantial in all areas)	5 (incapacitated)

Obsession Subtotal (add items 1-5) [ ]

	None	Mild	Moderate	Severe	Very Severe	Extreme
6. TIME SPENT ON COMPULSIONS*	0	1 (<1hr)	2 (1-3 hrs)	3 (3-8 hrs)	4 (8 –12 hrs)	5 (12 h - constant)

	Always resists	Resists most of the time	Moderate effort to resist	Some effort to resist	Yields to most	Completely yields to all
7. RESISTANCE TO COMPULSIONS	0 (or no need to resist)	1	2	3	4	5

	Complete control	Much control	Moderate control	Some control	Minimal control	No control
8. CONTROL OVER COMPULSIONS	0	1	2	3	4	5

	None	Mild	Moderate	Severe	Very Severe	Extreme
9. DISTRESS IF COMPULSIONS PREVENTED*	0	1 (slight distress)	2 (disturbing still manageable)	3 (marked distress for some)	4 (marked distress for all)	5 (overwhelming anxiety if delayed)

	None	Mild	Moderate	Severe	Very Severe	Extreme
10. INTERFERENCE FROM COMPULSIONS*	0	1 (slight)	2 (definite interference still manageable)	3 (substantial in one or more areas)	4 (substantial in all areas)	5 (incapacitated)

*CONSIDER MEDIATING ROLE OF AVOIDANCE

Compulsion Subtotal (add items 6-10) [ ]

	Excellent	Good	Fair	Poor	Absent
11. INSIGHT	0	1 (some lingering doubts)	2 (many unrealistic fears)	3 (overvalued ideas)	4 (delusional)