CY-BOCS-II

Clinical Version

By the Principal Developers of the
Yale-Brown Obsessive Compulsive Scale, Yale-Brown Obsessive Compulsive Scale-Second Edition, and Children's Yale-Brown Obsessive Compulsive Scale

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INTRODUCTION TO THE 2011 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). Shortly after its inception, the Children's Yale-Brown Obsessive-Compulsive Scale was created using the Y-BOCS structure. Like its adult counterpart, the CY-BOCS has been used as a primary outcome in virtually every major clinical trial involving youth with OCD. It has been translated into multiple languages and remains the standard for assessing symptom severity and treatment response. Despite this broad range of acceptance, over two decades of experience taught us that there is still room for improvement. Accordingly, we revised and created the CY-BOCS-II to address a number of issues that are reviewed below.

The Y-BOCS-II differed from the revised first edition (1989) in several ways. The most important changes were: 1) "resistance against obsessions" (item #4) was replaced by "obsession-free interval"; 2) the scoring of all items was 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 was given added emphasis as reflected in the instructions and anchor points for most items; 4) extensive modifications were made in the content and format of the Symptom Checklist; and 5) fine tuning of wording or format. Accordingly, this new edition of the CY-BOCS, the CY-BOCS-II, adopted a number of these changes, as well as added several others.

1) Item Changes: Like the Y-BOCS-II, the "resistance against obsessions" was eliminated. 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; indeed, several studies have supported this by showing that this item had the lowest correlation with the total Y-BOCS score. 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 our experiences with children suggested that they struggled to comprehend the item meaning as well. Thus, it has been abandoned in the CY-BOCS-II.

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) – the resistance against obsessions item was replaced with an item assessing "obsession-free interval." Our experiences with the Y-BOCS/CY-BOCS indicated how long patients were without intrusive thoughts improved assessment of the time-burden imposed by obsessions. The new item 2 ("obsession-free interval") examines 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. 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 suggested that the Y-BOCS/CY-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/CY-BOCS. For example, the old CY-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 (i.e., 0-40), 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. Of note, avoidance can be facilitated by family members. 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 a child who stops doing his homework because "once he starts, he has to re-write it over and over again until it's perfect". 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 CY-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.

5) Considering parent-child differences in response: Often in clinical interviews information is gathered from both parent and child to inform clinical judgment. This is particularly relevant in childhood OCD in which children are not required to have insight, may be embarrassed about their symptoms, and/or may not be willing to disclose symptoms. Alternatively, parents may not be aware of internal symptoms in their child or how much a child engages in rituals when away from them. Thus, a multiple informant model can be quite beneficial to account for the possibility of parent-child differences in reporting. In the present version, the clinician queries the child and the parent separately, recording the ratings that they provided. Thereafter, the clinician provides a final rating which is based on child and parent reports and clinical judgment. Importantly, the role of the clinician is not to simply record the answer given but rather to be a precise instrument for gathering the most accurate information. To that end, the clinician is encouraged to ask follow-up questions to parents and children as appropriate to clarify item content and responses.

6) 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 and the inclusion of both child and parent reports of symptom severity.

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/CY-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 youth diagnosed with obsessive-compulsive disorder (OCD). In general, the items depend on both child and caregiver report; however, the final rating is based on the clinical judgment of the rater. 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 caregiver and child volunteer information at any time during the interview, that information should 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 by either caregiver or child, then the informant discrepancy should be noted accordingly at the end of the interview (last item).

It is important for consistent week-to-week reporting that the same informant(s) are present for each rating session (e.g., same caregiver).

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

> "OBSESSIONS are thoughts, ideas or pictures that keep coming into your mind even though you do not want them. They may seem unpleasant, senseless, silly or embarrassing. "
>
> "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. These are thoughts that keep coming back over and over again.”
>
> "COMPULSIONS, on the other hand, are things that you feel you have to do although you may know that they do not make sense. Sometimes you may try to stop from doing them but this might not be possible. You might feel worried or angry or frustrated until you have finished what you have to do. You may also recognize that these actions are senseless or excessive. At times, you may try to resist doing them but this may prove difficult. Lastly, some children report that

> they 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 wash your hands over and over again even though they are not really dirty, or 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. For example, some children say that have a persistent irrational thought about endangering someone's life (obsession) while performing an activity, and that they need to mentally count up to a certain number while doing those activities to neutralize this worry.
>
> "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 for a child to not go to the bathroom at school because they are afraid of becoming contaminated by the bathrooms at school. ."
>
> "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 both caregiver and child understands them. It may be sufficient to remind the caregivers and children that obsessions are the thoughts or concerns and compulsions are the things one feels driven to do, including covert mental acts.

Have the caregivers and child enumerate current obsessions and compulsions in order to generate a list of target symptoms. Use the CY-BOCS-II Symptom Checklist as an aid for identifying recent and past symptoms. The endorsement on the Symptom Checklist is a composite report from both child and caregiver. 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. Moreover, the identification of past symptoms can aid in future research investigations. The lifetime obsessive-compulsive symptom profile may hold valuable information for characterizing possible subtypes of OCD. The term "current" symptoms refer to those present during the time frame being measured by the severity items of the CY-BOCS-II. In most instances, this time frame ranges from one to two weeks, the most common interval between visits in clinical trials. The CY-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 the most prominent symptoms as will likely be the major focus of assessment. Note, however, that the final severity score for each item should reflect a composite rating of all of the child'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. When using the CY-BOCS-II to rate the severity of symptoms not strictly classified under OCD (e.g., hair pulling in trichotillomania) in a child who otherwise meets criteria for OCD, it has been our practice to administer the CY-BOCS-II twice: once for conventional obsessive-compulsive symptoms and a second time for putative OCD-related phenomena. In this fashion separate CY-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 CY-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 CY-BOCS-II score is the sum of the consensus rating on 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. It is also possible to sum items separately for children and their caregiver to get severity estimates by the respective respondant.

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 CY-BOCS-II. They are not intended as measures of symptom severity. However, insight is important in youth with OCD as it has been shown to be associated with higher levels of OCD-related impairment and family accommodation.

Additional information regarding the development, use, and psychometric properties of the CY-BOCS, Y-BOCS and Y-BOCS-II can be found in:

Goodman WK, Price LH, Rasmussen SA, et al. (1989). The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part I. Development, use, and reliability. *Archives of General Psychiatry, 46,* 1006-1011.

Goodman WK, Price LH, Rasmussen SA, et al. (1989). The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part II. Validity. *Archives of General Psychiatry, 46*, 1012-1016.

Scahill L, Riddle MA, McSwiggin-Hardin M, Ort SI, King RA, Goodman WK, Cicchetti D, & Leckman JF. (1997). Children's Yale-Brown Obsessive-Compulsive Scale: Reliability and validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 844-852.

Storch EA, Rasmussen SA, Price LH, Larson MJ, Murphy TK, Goodman WK. (2010). Development and Psychometric Evaluation of the Yale-Brown Obsessive-Compulsive Scale Second Edition. *Psychological Assessment, 22,* 223-232.

Storch EA, Larson MJ, Price LH, Rasmussen SA, Murphy TK, Goodman WK. (2010). Psychometric Analysis of the Yale-Brown Obsessive-Compulsive Scale Second Edition Symptom Checklist. *Journal of Anxiety Disorders, 24,* 650-656.

Copies of a version of the CY-BOCS-II are available from Dr. Goodman on request at <wayne.goodman@mssm.edu>.

Name or ID_____

Date _____

Caregiver Respondent: _____

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, diseases, or contracting illness.
		02. **Excessive concern with contaminants or chemicals.** Examples: household cleansers, gasoline, radiation, pesticides and chemicals.
		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: sweat, 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.** This question may not be relevant for younger children (11 years and younger). Example: Woman afraid of conception if she swims in public pool.
		07. **Concerned with having an illness or disease or getting sick.***Examples: getting the flu or a 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/body image.
		09. **Fear might harm self or others because not careful enough.** Examples: irrational fear that if don't pick up toys that caregiver will trip on them and get seriously injured.
		10. **Fear might harm self or others on impulse.*** Examples: physically harming loved ones, stabbing or poisoning parents, pushing sibling in front of a car. *Distinguish from homicidal/suicidal intent.

		11. **Fear of being responsible for terrible events.** Examples: fire, burglary, flooding house, parents divorcing, caregiver dying.
		12. **Fear of blurting out obscenities or insults.** Examples: shouting blasphemies in church, yelling fire in the movie theatre, writing obscenities in a school paper.
		13. **Fear of doing something else embarrassing or inappropriate.*** Examples: sexual contact, spitting, taking off clothes in public, stealing things. *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 (e.g., on a test), 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 exceeding those of religious peer group.
		17. **Excessive fears of Satan or demonic possession**. Examples: the devil will possess my soul, sports teams with word devil in them, "666", pentangles.
		18. **Forbidden or improper sexual thoughts or images.*** Examples: unwanted sexual thoughts about family members or others; images of unacceptable acts; repetitive thoughts of sexual words/content. *Distinguish from paraphilias by asking about fantasy life. (This question may not be relevant for younger children).
		19. **Experiences unwanted sexual impulses.*** Examples: concerned that might "snap" and commit inappropriate sexual behavior such as grab someone. *Distinguish from paraphilias. (This question may not be relevant for younger children)
		20. **Excessive concerns about sexual orientation or gender identity.** Examples: child 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. This question may not be relevant for younger children
		21. **Need for symmetry or exactness.** Examples: certain things can't be touched or moved, toys or books organized in particular manner, bothered if pictures are not straight or toys 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 arranged perfectly.
		23. **Fear of saying the wrong thing**. Example: child may appear to have thought blocking because he/she is reviewing potential interpretation of what he/she is about to say. Expresses doubt when giving relatively straight forward responses.
		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, packaging information.

		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. Also may be concerned over loss of valuable piece of information if papers/items are discarded. *Distinguish from hobbies and concern with objects of monetary or sentimental value.
		27. **Fear of losing objects, information, or a person.** Examples: Child concerned that her "soul" would be changed by engaging in a certain behavior, or may be afraid that dog will be taken from yard while at school.
		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.
		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 record.

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: cleaning toys excessively; daily thorough washing of pets or school materials, asks for excessive washing of clothes.
		32. **Checking locks, stove, appliances, faucets, etc**. Examples: Checking that the doors are locked, stove is turned off, appliances unplugged.
		33. **Checking that nothing terrible did/will happen**. Examples: when returning home from school, check to make sure parent or pet did not die while they were at school
		34. **Checking that did not make mistake**. Examples: homework, counting money, writing.
		35. **Checking tied to somatic obsessions.*** Examples: repeatedly checking body for signs of skin cancer; asking family members for reassurance about health. *Distinguish from hypochondriasis.
		36. **Need to repeat routine activities or boundary crossings.** Examples: going through doorway; may get stuck trying to enter a building, doing/undoing rituals, taking clothes on/off, pattern walking, 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; if touches something with one hand, has to touch with the other.
		38. **Re-reading* or re-writing.** Examples: doubt information that just read so re-reads it, 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 or having an exchange with parents, brush teeth in a ritualistic manner.
		41. **Excessive religious rituals.** Example: Repeating prayers or biblical passages an inordinate number of times; confessing minor or perceived moral wrong-doings.
		42. **Ordering or arranging compulsions.** Example: straightening possessions on a desktop, straightening pictures, arranging toys in a particular manner, 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 parent if 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, school papers, collects useless objects. Bedroom can become obstacle course with piles of clutter. *Distinguish from hobbies and concern with objects of monetary or sentimental value. And, consider hoarding limits imposed by parents.
		47. **Picks up objects that most people would pass by**. Examples: shards of broken glass, rocks, pieces of paper with writing on them, old pencil nubs.
		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;difficulty throwing out trash; repeatedly checks school backpack to make sure nothing was lost, repeatedly checks to make sure previous nights homework assignments are packed .
		49. **Buys or hoards many unneeded items.** Examples: keeps 20 pens with them at all times, stores an excessive number of batteries in case needed, etc. *May not be symptom of OCD unless behavior is excessive (e.g., wastes a lot of money, or accumulates closet or school locker 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. Inflated sense of responsibility?
		51. **Need to do something until it feels "just right."** Examples: adjusts clothing, arranges possessions, repeats a behavior, 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*.** Examples: child says he/she has to blink a certain number or times or stare to neutralize an obsession. May be difficult to distinguish from motor tics of * Tourette's Syndrome.
		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 or with family member to stay certain distance 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 people because of obsessions, or makes family members avoid these triggers.**
		60. **Avoids contact (or makes family avoid contact) with contaminated objects or people**.
		61. **Avoids handling sharp or dangerous objects, or operating vehicles or machinery such as cars or saws (or makes family avoid contact), out of concern might harm others.**
		62. **Avoids 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, playing videogames, listening to radio or reading to shield from disturbing information.**
		65. **Avoids doing things, going places, or being with someone (or makes family avoid) that would trigger time consuming or onerous rituals** (e.g., washing, dressing, etc.).
		66. **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 the obsessive thoughts we discussed." [Make reference to the child's specific obsessions and change prompts accordingly to account for different respondents (e.g., child or parent alone, child and parent together.]

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.

Child Report	
Parent Report	
Overall Clinician Rating	

2. OBSESSION-FREE INTERVAL

   Q: "On average, what is the longest continuous period (or block) of time in which you do not have 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.

Child Report	
Parent Report	
Overall Clinician Rating	

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 get rid of 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.

Child Report	
Parent Report	
Overall Clinician Rating	

4. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS

Q: "How much do your obsessive thoughts bother or upset 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.

Child Report	
Parent Report	
Overall Clinician Rating	

5. INTERFERENCE DUE TO OBSESSIVE THOUGHTS

Q: "How much do your obsessive thoughts interfere with performance in school/the classroom, getting along with other kids, or in your family?" [If currently not attending school, determine how much performance would be affected if patient were in school.] "(Has your child or) 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, family, or school activities, but overall performance not impaired. Minimal avoidance.
2 = Moderate, definite interference with social, family, or school functioning, 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 school, but social life on hold or considerable family interference. 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 or missed considerable amount of school such that has to repeat a grade.

Child Report	
Parent Report	
Overall Clinician Rating	

"The next several questions are about your compulsions." [Make reference to the patient's specific symptoms and change prompts accordingly to account for different respondents (e.g., child or parent alone, child and parent together.]

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, praying or other mental rituals); 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.

Child Report	
Parent Report	
Overall Clinician Rating	

7. RESISTANCE AGAINST COMPULSIONS

Q: "How much of an effort do you make to resist doing your 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.

Child Report	
Parent Report	
Overall Clinician Rating	

8. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR

Q: "How strong is the urge to perform the compulsions?" [Pause] "How much control do you have over your 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.

Child Report	
Parent Report	
Overall Clinician Rating	

9. DISTRESS IF COMPULSIVE BEHAVIOR (OR AVOIDANCE) PREVENTED

Q: "How would you feel if you were 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).

Child Report	
Parent Report	
Overall Clinician Rating	

10. INTERFERENCE DUE TO COMPULSIONS

Q: "How much do your compulsive behaviors interfere with how you do in school, getting along with other kids, or in your family?" [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, family, or school activities, but overall performance not impaired. Minimal avoidance.
2 = Moderate, definite interference with social, family, or school functioning, 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 school, but social life on hold or considerable family interference. 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, e.g., social, family, and 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.

Child Report	
Parent Report	
Overall Clinician Rating	

[The remaining items refer to both obsessions and compulsions. Responses to these items are not included in total CY-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 believe 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 and/or parent'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 child'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 CY-BOCS, Y-BOCS and Y-BOCS-II can be found in:

Goodman WK, Price LH, Rasmussen SA, et al. (1989). The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part I. Development, use, and reliability. *Archives of General Psychiatry, 46,* 1006-1011.

Goodman WK, Price LH, Rasmussen SA, et al. (1989). The Yale-Brown Obsessive Compulsive Scale (Y-BOCS): Part II. Validity. *Archives of General Psychiatry, 46,* 1012-1016.

Scahill L, Riddle MA, McSwiggin-Hardin M, Ort SI, King RA, Goodman WK, Cicchetti D, & Leckman JF. (1997). Children's Yale-Brown Obsessive-Compulsive Scale: Reliability and validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 844-852.

Storch EA, Rasmussen SA, Price LH, Larson MJ, Murphy TK, Goodman WK. (2010). Development and Psychometric Evaluation of the Yale-Brown Obsessive-Compulsive Scale Second Edition. *Psychological Assessment, 22,* 223-232.

Storch EA, Larson MJ, Price LH, Rasmussen SA, Murphy TK, Goodman WK. (2010). Psychometric Analysis of the Yale-Brown Obsessive-Compulsive Scale Second Edition Symptom Checklist. *Journal of Anxiety Disorders, 24,* 650-656.

Copies of a version of the CY-BOCS-II is available from Dr. Goodman upon request.

Children's Yale-Brown Obsessive Compulsive Scale-II

PATIENT NAME_____ DATE_____
PATIENT ID_____ RATER_____
CAREGIVER RESPONDANT _____

CY-BOCS-II Total
Add items 1 to 10

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

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

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

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

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

Obsession Subtotal (add items 1-5) ☐

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

	Always resists or no need to resist	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	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 slight distress	Moderate disturbing still manageable	Severe marked distress for some	Very Severe marked distress for all	Extreme overwhelming anxiety if delayed
9. DISTRESS IF COMPULSIONS PREVENTED*	0	1	2	3	4	5

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

*CONSIDER MEDIATING ROLE OF AVOIDANCE

Compulsion Subtotal (add items 6-10) ☐

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