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The Yale-Brown Obsessive Compulsive Scale: factor analysis, construct validity, and suggestions for refinement

Brett J. Deacon, Jonathan S. Abramowitz^{*,1}

*Department of Psychiatry & Psychology, Mayo Clinic, 200 First St. SW,
Rochester, MN 55905, USA*

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Abstract

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is widely acknowledged as the gold standard measure of obsessive-compulsive disorder (OCD) symptom severity. Despite its popularity, a number of questions remain regarding the Y-BOCS' psychometric properties including: (a) whether obsessional and compulsive symptoms contribute independently to global OCD severity and (b) whether the Y-BOCS subscales are valid with respect to other measures of OCD. We examined these issues in a sample of 100 patients with a diagnosis of OCD. While our confirmatory factor analyses failed to reproduce any previously reported models of the Y-BOCS factor structure, exploratory factor analysis indicated a two-factor solution that assessed symptom severity (i.e., time, distress, and interference from obsessions and compulsions) as separate from resistance and control of obsessions and compulsions. In contrast to the Resistance/Control Subscale, the Severity Subscale demonstrated good psychometric properties and construct validity. Based on our findings we recommend revisions to scoring the Y-BOCS.

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Keywords: Yale-Brown Obsessive Compulsive Scale; Factor analysis; Psychometric properties; Obsessive-compulsive disorder

^{*} Corresponding author. Tel.: +1 507 284 4431; fax: +1 507 284 4345.

E-mail address: abramowitz.jonathan@mayo.edu (J.S. Abramowitz).

¹ Present address: Department of Psychology, P.O. Box 3415, University of Wyoming, Laramie, WY 82070, USA.

Obsessive–compulsive disorder (OCD) is an anxiety disorder involving: (a) senseless intrusive thoughts, doubts, images, or impulses that evoke anxiety and distress (Obsessions; e.g., thoughts of contamination, unwanted impulses to harm friends) and (b) the intentional performance of compulsive rituals and other neutralization strategies (Washing, Checking, Praying) aimed at reducing obsessional distress or preventing feared consequences. The most widely used clinician-administered interview for assessing the severity of OCD is the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b). The Y-BOCS, which is used consistently in research evaluating the effectiveness of pharmacological and cognitive-behavioral treatments for OCD, consists of two parts: a symptom checklist and a severity measure. Comprehensive reviews of the psychometric literature (e.g., Taylor, 1995, 1998) suggest that the severity measure possesses sound reliability, validity, and sensitivity to treatment. For this reason, the Y-BOCS is widely considered the “gold standard” measure of OCD severity.

Items included on the Y-BOCS were rationally derived based on the developers’ clinical experience and the *DSM-III* (American Psychiatric Association, 1980) diagnostic criteria for OCD (Goodman et al., 1989a, 1989b). The severity measure contains 10 core items that assess obsessions and compulsions separately on five dimensions: time, interference, distress, resistance, and control. Each item is rated from 0 (no symptoms) to 4 (severe symptoms); accordingly, the scale yields a total score (range: 0–40) as well as subscale scores for Obsessions and Compulsions (range: 0–20 for each). Six investigational items were also included in the original measure to assess characteristics associated with OCD symptom severity (e.g., avoidance, pathological responsibility, insight). However, most studies report results only from the 10 core items, and the psychometric properties of the investigational items have not been adequately examined. The scale’s core composition thus reflects a conceptualization of OCD in which the severity of obsessions and compulsions contribute independently to the global severity of the disorder.

It is important to examine the factor structure of the Y-BOCS to verify whether OCD symptom severity is best conceptualized according to the subscale composition proposed by Goodman et al. (1989a). To this end, six studies have reported factor analyses of the Y-BOCS severity scale. The results of these studies are summarized in Table 1. As can be seen, findings have been inconsistent with authors reporting one-, two-, or three-factor solutions. In some studies obsessions and compulsions form distinct factors (e.g., McKay, Danyko, Neziroglu, & Yaryure-Tobias, 1995), whereas in others common features of obsessions and compulsions (e.g., interference and distress) load together on the same factor (e.g., Amir, Foa, & Coles, 1997). This evidence for instability of the Y-BOCS’ factor structure raises questions about whether OCD severity distills neatly into obsessions and compulsions as is traditionally thought.

In addition, there is evidence that the items measuring resistance to obsessions and compulsions (items 4 and 9, respectively) do not fit well with the other eight

Table 1
Factor analytic studies of the Y-BOCS Severity Scale

Study	Y-BOCS version	Analytic procedure	Factors and items
Fals-Stewart (1992)	16-item ^a	EFA	Global impairment from OCD (1–16)
Kim et al. (1994)	10-item	EFA	Severity of obsessions (1, 2, 3, 5) Severity of compulsions (6, 7, 8, 10) Resistance to symptoms (4, 9)
McKay et al. (1995)	10-item	CFA	Obsessions (1, 2, 3, 4, 5) Compulsions (6, 7, 8, 9, 10)
Amir et al. (1997)	10-item	CFA	Disturbance (2, 3, 7, 8) Symptom severity (1, 4, 5, 6, 9, 10)
McKay et al. (1998)	10-item	CFA CFA	Obsessions (1, 2, 3, 4, 5) Compulsions (6, 7, 8, 9, 10) Disturbance (2, 3, 7, 8) Symptom severity (1, 4, 5, 6, 9, 10)
Moritz et al. (2002)	12-item	EFA	Severity of obsessions (1, 1b, 2, 3, 5) Severity of compulsions (6, 6b, 7, 8, 10) Resistance to symptoms (4, 9)
	10-item	EFA and CFA	Severity of obsessions (1, 2, 3, 5) Severity of compulsions (6, 7, 8, 10) Resistance to symptoms (4, 9)

Note. EFA: exploratory factor analysis; CFA: confirmatory factor analysis.

Y-BOCS items: 1: time with obsessions; 1b: obsession-free interval; 2: interference from obsessions; 3: distress from obsessions; 4: resistance to obsessions; 5: control over obsessions; 6: time with compulsions; 6b: obsession-free interval; 7: interference from compulsions; 8: distress from compulsions; 9: resistance to compulsions; 10: control over compulsions; 11: insight into OCD symptoms; 12: avoidance; 13: indecisiveness; 14: pathological responsibility; 15: slowness; 16: pathologic doubting.

^a 1b and 6b were excluded from Fals-Stewart's (1992) analysis of the 16-item version.

Y-BOCS severity items. Inspection of the factor loadings reported in the individual studies listed in Table 1 indicates that these items either form their own factor (e.g., Kim, Dysken, Pheley, & Hoover, 1994; Moritz et al., 2002) or demonstrate the weakest factor loadings in two-factor solutions (e.g., McKay et al., 1995; McKay, Neziroglu, Stevens, & Yaryura-Tobias, 1998). The resistance to compulsions item also showed weak correlations with the Y-BOCS total and subscale scores in a study by Woody, Steketee, and Chambless (1995). Moreover, both resistance items showed poor sensitivity to medication treatment in a study by Kim et al. (1994).

Factor analysis allows researchers to make inferences about the nature of a construct by examining the factor structure of a valid measure of that construct. Accordingly, previous factor analyses of the Y-BOCS have been used to generate hypotheses regarding the nature of OCD symptom severity. For example, on the

basis of their findings Amir et al. (1997) concluded that “the conventional division of OCD phenomenology into obsessions and compulsions may not reflect the structure underlying the different aspects of OCD symptoms” (p. 315). The results of factor analytic studies of the Y-BOCS, however, are informative only to the extent that this scale is an adequate measure of OCD symptom severity. In light of concerns regarding factor structure and validity of the resistance items it is important to determine the extent to which Y-BOCS factors adequately measure what they are intended to measure. Whereas previous studies have examined relationships between obtained Y-BOCS factors and measures of anxiety and depression, only one investigation has directly examined the construct validity of Y-BOCS subscales in relation to measures of OCD (Woody et al., 1995). Because this study used the rationally derived obsessions and compulsions subscales that have not received consistent empirical support, the construct validity of Y-BOCS factors requires more thorough investigation.

The present study was conducted with two aims. First, we examined the factor structure of the Y-BOCS severity scale in a clinical sample of OCD patients. Specifically, we used confirmatory factor analysis to determine the extent to which previously reported factor models best fit the data from our sample. Second, we directly assessed the construct validity of the factors we obtained using measures of OCD symptoms, OCD-related functional impairment, and anxiety and depression symptoms.

1. Method

1.1. Participants

One hundred adult patients (51 men and 49 women) assigned a primary diagnosis of OCD in our anxiety disorders clinic were included in the present study. Demographic characteristics of the sample were as follows (some demographic data were missing for some patients): the mean age was 35.8 (S.D. = 12.2) and 94.1% were Caucasian. Thirty-seven percent had a full-time job and 19.4% were unemployed. The sample was well educated as 46.8% had at least a bachelor's degree. Almost half of the patients (42.9%) were married. The average age of OCD onset was 16.7 years (S.D. = 9.8), 31.0% met *DSM-IV* criteria for a depressive disorder and 22.0% met criteria for another anxiety disorder.

1.2. Materials

The following interview measures were administered during the assessment: *Yale-Brown Obsessive Compulsive Scale* (Y-BOCS; Goodman et al., 1989a, 1989b): Current OCD symptom severity was assessed using the 10-item Y-BOCS, a semi-structured interview that consists of a symptom checklist and severity

scale. The severity scale assesses: (a) time spent, (b) interference, (c) distress, (d) resistance, and (e) control for obsessions and compulsions separately. Items (scored 0–4) are summed to yield a total score ranging from 0 (no symptoms) to 40 (very severe symptoms).

Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998): Insight into the senselessness of obsessions and compulsions was assessed with the BABS; a 6-item semi-structured clinician administered scale that measures conviction in obsessional fears during the past week. One or two specific obsessional beliefs (e.g., “I will get AIDS from flushing a public toilet,” “I could hit someone with my car without realizing”) are identified and then rated for the following: (a) conviction in the belief, (b) perception of others’ views, (c) explanation of differing views, (d) fixity of beliefs, (e) attempts to disprove beliefs, and (f) insight (recognition of a psychiatric etiology). Item scores range from 0 (normal) to 4 (pathological) and are summed to produce a total score ranging from 0 to 24. The scale has good psychometric properties as reported by Eisen et al. (1998).

Patients also completed a packet of self-report questionnaires as part of their evaluation. The following instruments were included in the present study:

Obsessive–Compulsive Inventory-Revised (OCI-R; Foa et al., 2002). The OCI-R is an 18-item questionnaire based on the earlier 84-item OCI (Foa, Kozak, Salkovskis, Coles, & Amir, 1998). Participants rate the degree to which they have been bothered or distressed by OCD symptoms in the past month on a 5-point scale from 0 (not at all) to 4 (extremely). The OCI-R assesses OCD symptoms across six factors: (a) Washing, (b) Checking, (c) Obsessions, (d) Mental Neutralizing, (e) Ordering, and (f) Hoarding. The excellent psychometric properties of the OCI-R are described by Foa et al. (2002).

Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961): The BDI is a 21-item self-report scale that assesses the severity of affective, cognitive, motivational, vegetative, and psychomotor components of depression. Scores of 10 or less are considered normal; scores of 20 or greater suggest the presence of clinical depression. The BDI has excellent reliability and validity and is widely used in clinical research (Beck, Steer, & Garbin, 1988).

Self-rating Anxiety Scale (SAS; Zung, 1971): The SAS contains 20 items that assess the frequency of anxiety symptoms. The scale measures primarily somatic symptoms and has demonstrated adequate internal consistency and test-retest reliability (Michaelson & Mavissakalian, 1983).

Sheehan Disability Scale (SDS; Sheehan, 1986). The SDS is a commonly used 3-item measure of the degree to which clinical symptoms interfere with work, social/leisure activities, and family/home responsibilities.

1.3. Procedure

Patients were evaluated in a multidisciplinary anxiety disorders specialty clinic within a large academic medical center. Study participants underwent a 1.5 h interview with a psychologist that included a functional assessment of OCD

symptoms, administration of the Y-BOCS symptom checklist and severity scale, and the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). Interviewers had received training in the administration of the Y-BOCS and MINI by attending a didactic seminar on these measures, observing the administration of the measures by an experienced clinician, and then administering the measure under observation by a more experienced interviewer who provided constructive feedback. Although interrater reliability for the Y-BOCS and each primary diagnosis was not formally examined, all assessors met with the second author to discuss diagnostic impressions, case conceptualization, and to formulate treatment recommendations for each patient. Patients were only included in the present study if there was 100% interrater agreement on OCD as a primary diagnosis.

2. Results

2.1. Sample Characteristics

Patients had a mean Y-BOCS severity score of 24.0 (S.D. = 5.4) and a mean score of 27.2 (S.D. = 13.7) on the OCI-R indicating moderately severe OCD symptoms. The mean BABS score was 8.2, (S.D. = 4.7), indicating generally good insight into the senselessness of OCD symptoms. Scores on the BDI ($M = 17.2$, S.D. = 10.8) and the SAS ($M = 40.5$, S.D. = 9.5) indicated moderate levels of depression and state anxiety. Mean scores on the SDS work, social, and home/family were (respectively) 5.9 (S.D. = 3.0), 6.2 (S.D. = 2.4), and 6.8 (S.D. = 2.5). The internal consistency of the Y-BOCS in the current sample was .78.

2.2. Confirmatory factor analysis

Using LISREL (Jöreskog & Sörbom, 1993) we tested the goodness-of-fit of all previously reported models of the Y-BOCS factor structure. All analyses were conducted using maximum likelihood estimation and were computed from the covariance matrix among the Y-BOCS items. Following Amir et al. (1997), we included five commonly used fit indices: (a) chi-square, (b) adjusted goodness of fit index (AGFI), (c) root mean square error of approximation (RMSEA), (d) comparative fit index (CFI), and (e) normed fit index (NFI). Following the suggestions of numerous authors (e.g., McKay et al., 1995; Moritz et al., 2002), the residuals of question pairs (time, interference, distress, resistance, and control) were correlated in each model.

Table 2 presents fit indices for the single factor model (Fals-Stewart, 1992), two-factor models (Amir et al., 1997; McKay et al., 1995, 1998), and three-factor model (Kim et al., 1994; Moritz et al., 2002). As can be seen, none of these models provided an adequate fit to the Y-BOCS data in the current sample. Chi-square

Table 2
Relative fit of models of the Y-BOCS Severity Scale

Model and study	χ^2	df	P	AGFI	RMSEA	NFI	CFI
One factor (Fals-Stewart, 1992)	89.99	30	.00	.63	.17	.71	.76
Two factors (McKay et al., 1995)	68.41	29	.00	.70	.14	.77	.82
Two factors (Amir et al., 1997)	83.53	29	.00	.64	.16	.72	.77
Three factors (Kim et al., 1994 and Moritz et al., 2002)	68.71	27	.00	.67	.15	.77	.82

Note. AGFI: adjusted goodness of fit index; RMSEA: root mean square error of approximation; NFI: normed fit index; CFI: comparative fit index.

values for each model were highly significant. AGFI values were considerably less than the cutoff of .80 recommended by Cole (1987). RMSEA values for each model exceeded the criterion of .05 recommended for adequate fit (Browne & Cudeck, 1993). Finally, CFIs and NFIs were well below 1.0, the value considered to represent optimal adequate model fit (Jöreskog & Sörbom, 1993). Because these results indicate that none of the previously reported factor models of the Y-BOCS adequately represent data from the present sample, the decision was made to adopt an exploratory factor analytic approach.

2.3. Exploratory factor analysis

A Principal Components Analysis (PCA) was used to explore the factor structure of the 10 Y-BOCS items. Factors were rotated using oblique (oblimin) rotation given previous research indicating that Y-BOCS factors are strongly correlated (e.g., Amir et al., 1997). The number of factors to retain was determined primarily by parallel analysis, a statistical procedure for determining the break in the scree plot that has been shown to be one of the most accurate techniques for this purpose (Zwick & Velicer, 1986). Following the recommendations of Longman, Cota, Holden, and Fekken (1989), parallel analyses were conducted using both the mean and 95th percentile eigenvalues.

The first four eigenvalues were 3.6, 1.9, 1.0, and 0.9. Parallel analysis indicated a two-factor solution for both the mean and 95th percentile eigenvalues that accounted for 55.1% of the total item variance. As a result, the PCA was repeated specifying a two-factor solution. Table 3 presents the item means and standard deviations and factor loadings for the two-factor solution. The first factor consisted of 6 items with salient loadings (>.40) and assessed the time, interference, and distress associated with obsessions and compulsions. Accordingly, we termed this factor “Severity.” The second factor consisted of 4 items with salient loadings and assessed the degree of resistance and control associated with obsessions and compulsions. We, therefore, termed this factor “Resistance/Control.”

As shown by the pattern matrix in Table 3, the two-factor solution demonstrated excellent simple structure and stability according to the criteria suggested

Table 3
 Pattern matrix from Principal Components Analysis of the Y-BOCS Severity Scale

Item	<i>M</i>	S.D.	Factor I	Factor II	<i>h</i> ²
1. Time spent on obsessions	2.77	0.94	.75	−.08	.55
2. Interference from obsessions	2.05	1.05	.78	−.06	.68
3. Distress from obsessions	2.61	0.70	.67	−.09	.39
4. Resistance to obsessions	1.90	1.18	−.07	.70	.52
5. Control over obsessions	2.70	0.86	.39	.60	.68
6. Time spent on compulsions	2.40	1.00	.73	−.08	.57
7. Interference from compulsions	1.86	1.03	.77	.12	.64
8. Distress from compulsions	2.59	0.74	.53	.16	.43
9. Resistance to compulsions	2.39	1.03	−.18	.85	.68
10. Control over compulsions	2.69	0.80	.16	.78	.66

Note. Factor loadings $\geq .40$ are listed in boldface type.

by [Guadagnoli and Velicer \(1988\)](#) and [Thurstone \(1947\)](#). Each factor consisted of an adequate number of items (i.e., 4 or more; [Guadagnoli & Velicer, 1988](#)) with loadings above .60. No items had salient loadings on more than one factor and there were no items that failed to load on either factor. Based on these criteria, each factor obtained in the present study appears stable.

Finally, to determine the psychometric properties of the two Y-BOCS components we calculated subscales based on the factor structure reported in [Table 3](#). The decision to use subscales as opposed to factor scores was based on considerations of interpretability and clinical utility. Internal consistencies for the subscales were .80 and .73 for the Severity and Resistance/Control Subscales, respectively. The correlation between the two subscales was mild ($r = .25$, $P = .01$) and correlations with the Y-BOCS total scores were strong: .84 for Severity and .70 for Resistance/Control.

For each of the 10 scale items, we calculated corrected item-total correlations with: (a) the corresponding subscale total score and (b) the Y-BOCS total score. As shown in [Table 4](#), each item was at least moderately related to its corresponding subscale. All 6 items in the Severity Subscale and the two control items in the Resistance/Control Subscale were sufficiently correlated with Y-BOCS total scores. However, the two resistance items failed to demonstrate adequate correlations with Y-BOCS total scores ([Nunnally & Bernstein, 1994](#)).

2.4. Correlates of the Y-BOCS subscales

[Table 5](#) presents correlations between Y-BOCS total scores, the two subscale scores, and various measures of clinical symptoms and functional impairment related to OCD. As can be seen, the total score was significantly correlated with each criterion measure. Despite their shared variance with total scores, the subscales demonstrated substantially divergent patterns of associations with other criterion variables. Specifically, the Severity Subscale evidenced moderately high

Table 4

Internal consistency and corrected item-total correlations of the Yale-Brown Obsessive Compulsive Scale

	Corrected item-total correlation	
	Subscale	Total score
Severity Subscale		
Time spent (obsessions)	.55	.45
Time spent (compulsions)	.62	.50
Interference (obsessions)	.62	.52
Interference from compulsions	.68	.62
Distress from obsessions	.48	.39
Distress from compulsions	.44	.44
Resistance/Control Subscale		
Resistance to obsessions	.45	.26
Resistance to compulsions	.52	.26
Control of obsessions	.54	.60
Control of compulsions	.62	.52

Table 5

Correlations between Y-BOCS Total Score, Subscales, and measures of OCD-related symptoms

Measure	Y-BOCS Scale		
	Total Score	Severity Subscale	Resistance/Control Subscale
Obsessive Compulsive Inv.-Revised	.45**	.49**	.13
Brown Assessment of Beliefs Scale	.34*	.01	.55**
Beck Depression Inventory	.46**	.49**	.16
Self-rating Anxiety Scale	.38**	.43**	.08
Sheehan Disability Scale-Work	.38**	.62**	-.16
Sheehan Disability Scale-Social	.35**	.53**	-.10
Sheehan Disability Scale-Home/family	.55**	.52**	.27*

Note. * $P < .05$, ** $P < .01$. Y-BOCS: Yale-Brown Obsessive Compulsive Scale; OCD: obsessive-compulsive disorder.

and significant correlations with measures of obsessions and compulsions, depression and anxiety symptoms, and functional impairment; but was unrelated to insight into the senselessness of OCD symptoms ($r = .01$). In contrast, the Resistance/Control Subscale was significantly correlated with insight ($r = .55$) and functional impairment at home ($r = .27$) but was unrelated to other clinical symptoms.

3. Discussion

Despite widespread use of the Y-BOCS as the gold standard measure of OCD severity, basic questions concerning this scale remain unanswered. Factor analytic

studies have reported inconsistent results that cast doubt on the originally proposed division of OCD symptom severity into obsessions and compulsions. In addition, the construct validity of factors obtained in previous studies is largely unknown. The present study addressed these issues in a sample of 100 outpatients diagnosed with OCD. First, we conducted confirmatory and exploratory factor analyses to determine the underlying structure of the Y-BOCS. Second, we investigated the construct validity of Y-BOCS factors through examining correlations with other measures of OCD and related clinical symptoms. Our aim was to determine the adequacy of the Y-BOCS in capturing the nature of OCD symptom severity.

None of the previously reported models of the Y-BOCS factor structure could be reproduced using data from our sample. As a result, it was necessary to use an exploratory approach to examine the structure of the Y-BOCS. Principal Components Analysis yielded a clearly defined two-factor model that has not been previously reported in the literature. The “Severity” subscale was comprised of 6 items assessing the time, interference, and distress associated with obsessions and compulsions. The “Resistance/Control” subscale contained 4 items measuring the degree of resistance and control associated with obsessions and compulsions. These novel results add to an already inconsistent literature on the Y-BOCS’ factor structure and provide further evidence for the instability of the scale.

A primary goal of the present study was to examine the construct validity of the factors we obtained through comparisons with other measures of OCD symptom severity. While Y-BOCS total scores were uniformly related to measures of OCD and related symptoms (e.g., insight, functional impairment, anxiety, depression), a very different picture emerged when we examined the Y-BOCS at the subscale level. Similar to total scores, the Severity Subscale was moderately associated with OCD symptoms, functional impairment, and measures of general distress. In contrast, the Resistance/Control Subscale was unrelated to these variables but was substantially related to insight into the senselessness of obsessions and compulsions. Our findings are consistent with previous research (e.g., Kim et al., 1994; Woody et al., 1995) and suggest that the Resistance/Control items (40% of the Y-BOCS items) do not meaningfully contribute to the measurement of OCD symptom severity. In addition, our results indicate that even the most valid Y-BOCS items demonstrate good convergent validity but poor discriminant validity.

Several factors might account for the poor validity of the resistance and control items. As Woody et al. (1995) have pointed out, clinical experience demonstrates that patients often cannot distinguish between attempts to resist their obsessional and compulsive symptoms and their success in controlling them. Another factor is that the failure to resist or control OCD symptoms may not necessarily represent a more severe form of the disorder. Consistent with contemporary cognitive-behavioral accounts of OCD (e.g., Salkovskis, 1985, 1999), our results suggest that individuals with greater insight into the

senselessness of their symptoms are less likely to attempt to resist or control them. Thus, high scores on the resistance and control items are ambiguous and, depending on the individual, might reflect attempts to prevent the occurrence of catastrophe or alternatively, a lack of concern about the occurrence of feared outcomes. Another problem with the resistance and control items is that decreased attempts to resist and control obsessions are rated as more pathological, yet cognitive-behavioral therapy aims to help patients learn that they do not need to resist or control their obsessional thinking in order to prevent feared outcomes. Thus, the sensitivity to treatment of these items may be problematic.

Our findings suggest that the use of total scores, as well as obsessions and compulsions subscale scores, is likely to lead to underestimation of OCD symptom severity due to the poor psychometric characteristics of the resistance and control items. As a result, there are sufficient empirical grounds for revising the Y-BOCS. While other authors have reached this conclusion, most have advocated alternative scoring methods for the existing 10-item scale according to their own factor analytic findings (e.g., [Moritz et al., 2002](#)). Given the growing body of research indicating that the Y-BOCS has an unstable factor structure and contains items with poor validity, we suggest that the resistance and control items could be deleted from the scale without unduly affecting its performance. Future studies might compare our recommended 6-item version with the standard 10-item severity scale.

In summary, our results highlight a number of psychometric problems with the Y-BOCS and provide further evidence regarding the structure of OCD. First, the originally proposed division of OCD severity into obsessions and compulsions, as embodied in the Y-BOCS, appears inaccurate. Clinical observations, contemporary empirically based theoretical accounts of OCD (e.g., [Rachman, 1998](#); [Salkovskis, 1999](#)), and research on OCD symptom themes (e.g., [Abramowitz, Franklin, Schwartz, & Furr, 2003](#); [Leckman et al., 1997](#)) support the view that obsessive–compulsive symptomatology does not distill neatly into obsessions and compulsions. Second, as measured by the Y-BOCS, resistance and control are poor measures of OCD severity. On the basis of existing research we have suggested a novel scoring scheme that would appear to increase the validity of the Y-BOCS; yet researchers and clinicians alike will benefit from the development of additional empirically-based OCD symptom interview measures based on current knowledge about the psychopathology of OCD.

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