

# Obsessive-compulsive disorder (OCD)

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## What you need to know

Obsessive-compulsive disorder (OCD) is a disorder in the Clinical psychology option (Papers 3 and 4). You should be able to:

1. **Diagnose it with ICD-11:** what obsessions and compulsions are, the common **types** of each, and when they count as a disorder, with a case study such as **Rapoport (1989), "Charles"**.
2. **Describe two measures:** the **Maudsley Obsessive-Compulsive Inventory (MOCI)** and the **Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)**.
3. **Explain OCD biologically:** the **biochemical** and **genetic** explanations.
4. **Explain OCD psychologically:** the **cognitive** (thinking error), **behavioural** (operant conditioning) and **psychodynamic** explanations.
5. **Describe treatments:** **SSRIs** (drugs), **exposure and response prevention (ERP)** with a study such as **Lehmkuhl et al. (2008)**, and **cognitive-behavioural therapy (CBT)**, through the key study **Lovell et al. (2006)**, CBT given by telephone.
6. **Evaluate all of it**, using the issues, debates and methods the syllabus names: interviews, case studies, quantitative and qualitative data, psychometrics, validity, reliability, individual and situational explanations, nature versus nurture, reductionism versus holism, determinism versus free will, idiographic versus nomothetic, cultural differences and the use of children in research.

Before 2024 this topic was "obsessive-compulsive and related disorders" and also covered **hoarding disorder** and **body dysmorphic disorder (BDD)**. They are **not** on the current syllabus; they appear briefly below only because older questions ask about them.

## Understand it

### Obsessions and compulsions

- An **obsession** is a thought, image or urge that **keeps returning** (it is **persistent** and **recurrent**), pushes into the mind against the person's will (**intrusive** and **unwanted**), and causes **anxiety**. The person tries to ignore it, push it away or cancel it out.
- A **compulsion** is a **repetitive** action, or a **mental act** such as counting or praying, that the person feels **driven** to carry out, usually in response to an obsession, following **rigid rules** or until it feels "just right". It reduces the anxiety for a short time, but it is **excessive**: it is out of proportion to any real danger, or has no realistic link to it.

The obsession is the **thought**; the compulsion is the **act**. "She is obsessed with hand-washing" mixes the two up: the obsession is the fear of germs, and the washing is the compulsion.

| Common obsessions (thoughts)                                                                             | Common compulsions (acts)                                                                       |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <b>Contamination</b> : germs, dirt, illness, bodily fluids                                               | <b>Washing and cleaning</b> : hands, body, clothes, the home                                    |
| <b>Harm</b> : that you or someone you love will be hurt, or that you will cause it (a fire, an accident) | <b>Checking</b> : locks, switches, the cooker, that nobody was hurt                             |
| <b>Order and symmetry</b> : things must be even, lined up or "just right"                                | <b>Ordering and arranging</b> objects in a fixed pattern                                        |
| <b>Doubt</b> : not being sure something was done properly                                                | <b>Counting and repeating</b> actions or words a set number of times                            |
| <b>Unwanted taboo thoughts</b> (violent, sexual or religious) that horrify the person                    | <b>Mental acts</b> : praying, repeating phrases, reviewing memories; <b>seeking reassurance</b> |

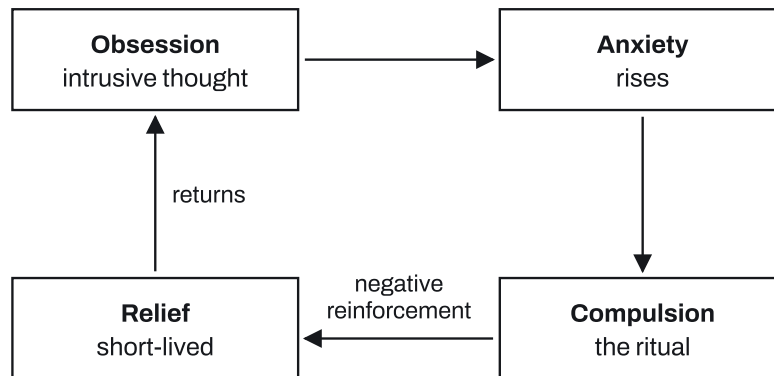
Hoarding (keeping things that most people would throw away) is often listed as a compulsion in mark schemes, but in ICD-11 **hoarding disorder** is a separate diagnosis. Kleptomania, pyromania and gambling are **impulse control disorders**, not OCD.

### ICD-11: when it is a disorder

ICD-11 diagnoses OCD when:

1. there are **persistent obsessions or compulsions, or (most often) both**;
2. the compulsions are carried out in response to the obsessions, by rigid rules, to reduce anxiety or get a sense of completeness;
3. they are **time-consuming** (for example, **more than an hour a day**), or cause **significant distress, or impair** personal, family, social, educational or work life (missed lessons, lost sleep, avoiding friends);
4. the symptoms are not better explained by another disorder, a drug or a medical condition.

ICD-11 also asks how much **insight** the person has: most know their fears are unreasonable, but some are convinced they are true.



### A case study: Rapoport (1989), "Charles"

Judith Rapoport, a psychiatrist in the USA, described **Charles**, a **14-year-old** boy with severe washing rituals. He spent **hours each day washing**, following a fixed routine, and the rituals disrupted his schooling. He avoided anything he thought was **sticky**. He was treated with the drug **clomipramine**, which (like an SSRI) increases serotonin. His symptoms improved, but after about **a year** he developed **tolerance** to the drug and the symptoms returned. Charles had OCD but was **not** treated with ERP, so he cannot be used as an ERP case study.

### Measure 1: the Maudsley Obsessive-Compulsive Inventory (MOCI)

The **MOCI** (Hodgson and Rachman, 1977) is a **self-report questionnaire** of **30 statements**, each answered **true** or **false**. It takes about **5 minutes**. Its items fall into four groups:

- **checking** (e.g. having to check taps or doors several times);
- **washing** or cleaning;
- **slowness** (taking a long time over everyday tasks because they must be done exactly);
- **doubting** (worrying that things were not done properly).

Each answer that matches OCD scores 1, so the total runs from **0 to 30**; the higher the score, the more obsessive-compulsive the person. Mark schemes treat a score above about 18 as suggesting OCD. It shows **which kinds** of symptom a person has, but not how much time they take or how distressing they are, and it misses types it does not ask about (such as unwanted taboo thoughts).

### Measure 2: the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)

The **Y-BOCS** (Goodman et al., 1989) measures **how severe** a person's OCD is.

1. **Symptom checklist**: the person and clinician go through a list of common obsessions and compulsions and mark the ones the person has.

2. **Severity scale: 10 items**, 5 about obsessions and the same 5 about compulsions: **time** taken up, **interference** with life, **distress**, how hard the person **resists**, and how much **control** they have.
3. Each item is rated on a **5-point scale** from **0 to 4**: **none, mild, moderate, severe, extreme**. Each item has its own wording, but all follow this pattern.
4. The total runs from **0 to 40** ( $10 \times 4$ ).

| Total | Severity                |
|-------|-------------------------|
| 0–7   | subclinical (very mild) |
| 8–15  | mild                    |
| 16–23 | moderate                |
| 24–31 | severe (marked)         |
| 32–40 | extreme                 |

A score of **16 or more** is usually taken as clinically significant OCD. The Y-BOCS is normally given by a clinician as a **semi-structured interview** (about 30 minutes), but there is also a **self-report** version (the one Lovell et al. used). It is repeated during and after treatment to see whether symptoms are falling.

## Evaluating diagnosis and measures

| Issue                                    | For                                                                                                                               | Against                                                                                                                                                                           |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Interviews</b>                        | The clinician can ask follow-up questions, check what the person means and notice signs                                           | The person may be <b>embarrassed</b> about taboo thoughts or rituals and say little; a young person may not have the words; a parent in the room may make them play symptoms down |
| <b>Psychometrics</b>                     | Standardised items and scoring; a score can be compared with norms, with other patients and with the same person <b>over time</b> | A number cannot show the person's own experience or the meaning of their rituals                                                                                                  |
| <b>Quantitative and qualitative data</b> | Scores are easy to compare and analyse                                                                                            | A true/false answer gives no reasons; qualitative interview data (what the rituals feel like) gives depth but is harder to compare                                                |
| <b>Validity</b>                          | Y-BOCS items match the ICD-11 features (time, distress, interference)                                                             | <b>Social desirability</b> : people may under-report; some may over-report; a measure such as the MOCI misses some types of OCD                                                   |
| <b>Reliability</b>                       | Fixed questions and scoring; the same person should get a similar score twice (test-retest)                                       | Scores can change with the day's mood; two clinicians may rate the same interview differently                                                                                     |

A diagnosis can also simply be wrong: a **type 1 error** (false positive) labels someone with OCD who does not have it, and a **type 2 error** (false negative) misses someone who does.

## Biological explanation 1: biochemical

OCD is linked to brain chemistry, especially **low serotonin** activity. Serotonin is a **neurotransmitter**, a chemical messenger between neurons, and helps regulate mood and anxiety. The strongest evidence is that drugs which **raise serotonin** (SSRIs, and clomipramine in Charles) reduce OCD symptoms in many patients, while drugs that work on other chemicals help much less. **High dopamine** activity has also been linked to OCD, especially to repetitive behaviour. (Dopamine **deficiency** is not the explanation.)

## Biological explanation 2: genetic

The genetic explanation says a tendency to OCD can be **inherited**, so it **runs in families**. Lewis (1936) found that **37%** of his patients with OCD had a parent with the disorder and **21%** had a sibling with it. Twin studies find that **identical (MZ)** twins, who share all their genes, are more likely both to have OCD than **non-identical (DZ)** twins, who share about half. No single "OCD gene" has been found; many genes each seem to add a small risk, including genes that affect serotonin. Concordance is never 100%, so the environment must matter too.

## Psychological explanation 1: cognitive (thinking error)

Almost everyone has intrusive thoughts. The cognitive explanation says the difference in OCD is how the thought is **interpreted**. Salkovskis (1985) argued that people with OCD feel an **inflated sense of responsibility**: "If I have thought about a fire and don't check, it will be my fault if the house burns down." Other **thinking errors** include:

- **overestimating threat** (an unlocked window "means" a burglary tonight);
- **thought-action fusion**: believing that thinking something makes it more likely to happen, or is as bad as doing it;
- a need for **certainty** and **perfection**.

The anxiety this causes leads to a compulsion to **neutralise** the thought, which seems to work, so the faulty belief is never tested.

## Psychological explanation 2: behavioural (operant conditioning)

The obsession causes anxiety. Performing the compulsion makes the anxiety drop, and that relief is **negative reinforcement** (an unpleasant feeling is taken away), so the compulsion becomes more likely next time. Because the person always does the ritual, they never learn that the feared outcome would not have happened anyway. A compulsion can also be **positively reinforced**, for example when a child is praised for being extremely tidy. Mowrer's two-process idea adds that the original fear may be learned by **classical conditioning** (a neutral object linked with a frightening event) and then **maintained** by operant conditioning.

## Psychological explanation 3: psychodynamic

Freud linked OCD to the **anal stage** of psychosexual development (about 18 months to 3 years), when toilet training creates conflict between the child's wishes and the parents' demands.

1. If toilet training is **very harsh** or **very early**, the child may become **fixated** at the anal stage. An **anally retentive** adult is overly neat, orderly, controlling and stubborn.
2. In adulthood, the **id** (aggressive or "dirty" urges) clashes with a strict **superego** (rules about cleanliness and control). The **ego** must defend against the anxiety this causes.
3. Obsessions are the forbidden urges breaking through; compulsions are **defence mechanisms** that "undo" or keep down those urges, so repeated cleaning or ordering soothes anxiety from the early conflict.

Freud's "Rat Man" (1909) was his best-known case of what he called obsessional neurosis.

## Treatment 1: SSRIs

**Selective serotonin reuptake inhibitors** (SSRIs, such as fluoxetine or sertraline) are the main drugs for OCD.

1. Normally, after serotonin crosses the synapse and passes on its message, the sending neuron **reabsorbs** it (**reuptake**).
2. An SSRI **blocks** this reuptake, so **more serotonin stays in the synapse** and keeps stimulating the receiving neuron's receptors.
3. With more serotonin activity, the person feels **less anxiety** about their obsessions, so the urge to perform the compulsion weakens.

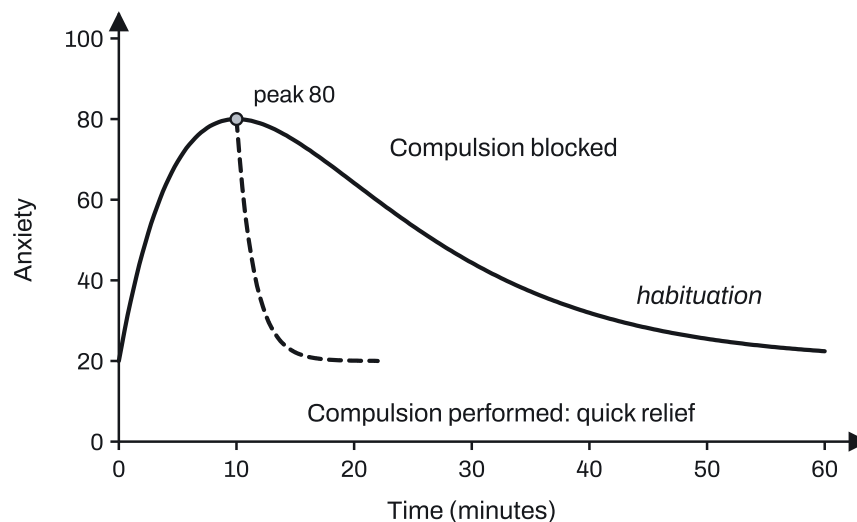
For OCD, SSRIs are given at **higher doses** than for depression and take **several weeks** to work fully. A review of **17** trials with **3097** patients (Soomro et al., 2008) found SSRIs more effective than a placebo at lowering Y-BOCS scores. Side effects include nausea, headaches and sleep problems, and symptoms often return when the drug is stopped.

## Treatment 2: exposure and response prevention (ERP)

ERP is the **behavioural** core of therapy for OCD.

1. **Assessment**: therapist and patient identify the obsessions, the compulsions and the situations that trigger them.
2. **Hierarchy**: they list the trigger situations from least to most anxiety-provoking.
3. **Exposure**: starting at the bottom, the patient deliberately faces a trigger (touching a "contaminated" object, leaving a switch unchecked).
4. **Response prevention**: the patient **does not** perform the compulsion, using coping statements to get through the rising anxiety.
5. **Habituation**: the anxiety peaks and then falls on its own. The patient learns that the feared outcome does not happen and that the anxiety fades without the ritual.

6. They move up the hierarchy, in sessions and as **homework**, until the triggers cause little anxiety.



**Lehmkuhl et al. (2008):** a **case study** of **Jason**, a **12-year-old** boy with both **autism** and **OCD**. He had **contamination** fears: he would not touch things other children had touched, such as door handles, library books or papers, would not sit on some chairs and avoided turning pages with his hands. He had **ten 50-minute sessions** of CBT with ERP over **16 weeks**. Jason could not name specific obsessions, so the cognitive part focused on recognising his feelings of distress and using **coping statements** ("Nothing bad will happen"; "Doing the exposures will help me get better"), with a thought record between sessions. In exposure he touched everyday objects such as **lift (elevator) buttons** and **door handles**, starting at the bottom of his hierarchy, and repeated each until his anxiety fell. His **Y-BOCS** score fell from **18 to 3**, and it was still low **3 months** later.

### Treatment 3: CBT, and the key study Lovell et al. (2006)

CBT for OCD combines ERP with work on the **thinking errors**:

1. **Psychoeducation**: explaining how intrusive thoughts, anxiety and compulsions feed each other (the cycle in the first diagram).
2. **Self-monitoring**: a diary of each obsession, the feeling and the compulsion, as homework.
3. **Cognitive restructuring**: questioning the faulty belief ("Has a disaster ever happened because you didn't check?") and replacing it with a realistic one.
4. **Exposure and response prevention** and **behavioural experiments** to test the belief in real life.

#### Lovell et al. (2006)

**Aim**: to see whether CBT (ERP) given by **telephone** is as effective as the same therapy given **face to face**.

**Design**: a **randomised controlled non-inferiority trial** (independent groups). It had no untreated control group, because the question was whether telephone therapy is **no worse than** face-to-face therapy, so both groups needed treatment.

**Participants**: **72** outpatients with OCD from two psychology departments in the UK.

- **Included:** a diagnosis of OCD, a Y-BOCS score of **16 or more**, and age **16–65**.
- **Excluded:** obsessional slowness, organic brain disease, substance misuse, severe depression or suicidal intent, and anyone who had been taking antidepressants or anti-anxiety drugs for **less than 3 months** (so a new drug could not explain any change).

**Procedure:** both groups had **10 weekly sessions** of ERP. The patient built a hierarchy of feared situations, set weekly targets for exposure, practised for about an hour a day and recorded progress on homework sheets; a relative or friend could act as a co-therapist.

| Group               | Sessions                                                                                                               |
|---------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Face to face</b> | 10 sessions of about <b>1 hour</b>                                                                                     |
| <b>Telephone</b>    | first and last sessions face to face (1 hour each); the <b>8</b> in between by telephone, up to <b>30 minutes</b> each |

**Measures** (all self-report): the **Y-BOCS** (self-report version), the **Beck Depression Inventory (BDI: 21 items, each 0–3, maximum 63)** and a **client satisfaction questionnaire**. Patients were assessed **twice before treatment, 4 weeks apart**, after treatment, and at **1, 3 and 6 months** follow-up.

**Results:** the average Y-BOCS score before treatment was about **25** (moderate to severe). Both groups improved by similar amounts, and the improvement lasted to 6 months. At 6 months the difference between the groups' Y-BOCS scores was only **–0.55 points** (95% confidence interval **–4.26 to 3.15**), which is not significant. About **72%** of patients made a clinically significant improvement (**77%** with telephone, **67%** face to face). Satisfaction was high in both groups.

**Conclusion:** telephone CBT was as effective as face-to-face CBT and patients were as satisfied, while using about half the therapist time per session.

**Evaluation:** random allocation and the same therapy, measures and timings for both groups make it **reliable** and fair; the **quantitative** scores allow statistical tests; the 6-month follow-up shows the gains lasted. But all measures were **self-reports** (social desirability), the patients came from one country where CBT is common, and the exclusions limit who the result applies to.

## Evaluating the explanations and treatments

| Issue                        | Explanations                                                                                                                                                                                                                                          | Treatments                                                             |
|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Nature versus nurture</b> | Biochemical and genetic are <b>nature</b> ; behavioural is <b>nurture</b> ; cognitive and psychodynamic mix both (a thinking style, early experiences). Family patterns could be inherited <b>or</b> learned, as a child can copy a parent's rituals. | SSRIs change biology; ERP and CBT assume OCD can be <b>unlearned</b> . |

| Issue                                              | Explanations                                                                                                                                                                    | Treatments                                                                                                                                                                                                                                                   |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Reductionism versus holism</b>                  | Biochemical and genetic explanations reduce OCD to chemicals or genes and ignore thoughts and upbringing.                                                                       | SSRIs are <b>reductionist</b> (serotonin only) and may not help when thinking errors keep OCD going. CBT is more <b>holistic</b> : thoughts, feelings, behaviour and the body's anxiety response.                                                            |
| <b>Determinism versus free will</b>                | All the explanations are <b>deterministic</b> : genes, chemicals, reinforcement or the unconscious cause the disorder, and the person did not choose it.                        | The patient <b>chooses</b> to take tablets or to face triggers without the ritual, so treatment allows <b>free will</b> .                                                                                                                                    |
| <b>Individual and situational</b>                  | Biological, cognitive and psychodynamic explanations are <b>individual</b> (inside the person); the behavioural explanation is <b>situational</b> (rewards in the environment). | ERP is <b>situational</b> (the patient unlearns anxiety in the trigger situations), but each hierarchy is <b>individual</b> ; SSRI dose is adjusted to the person.                                                                                           |
| <b>Case studies; idiographic versus nomothetic</b> | Charles is <b>idiographic</b> : rich detail, but one boy. Twin studies are <b>nomothetic</b> .                                                                                  | Jason: detailed and tracked over time, but one boy who also had autism, and the therapist-researcher may be biased.<br>Lovell's 72-patient trial is nomothetic; each hierarchy is idiographic.                                                               |
| <b>Use of children in research</b>                 | Studying children shows how OCD begins.                                                                                                                                         | Treating children early stops rituals becoming fixed; parents give consent. But children may not be able to describe their thoughts or use coping statements, ERP may be too upsetting for very young children, and drug side effects need close monitoring. |
| <b>Cultural differences</b>                        | Which obsessions are common (religious, cleanliness) varies with culture.                                                                                                       | SSRIs act on the body in the same way everywhere; talking therapies may seem a Western idea, and stigma may stop people describing their obsessions. Telephone therapy helps people far from a clinic.                                                       |

## Key facts and formulas

There is no formula list in the 9990 exam. "Learn it" means you must remember it.

| Fact                                                                                                      | Status |
|-----------------------------------------------------------------------------------------------------------|--------|
| Obsession: persistent, recurrent, intrusive, unwanted thought, image or urge that causes anxiety.         | Learn  |
| Compulsion: repetitive act or mental act the person feels driven to do, by rigid rules, to reduce anxiety | it     |

| Fact                                                                                                                                                                                                                                                                         | Status   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| ICD-11 OCD: obsessions and/or compulsions (usually both); time-consuming (e.g. more than 1 hour a day) or significant distress or impairment in personal, family, social, educational or work life                                                                           | Learn it |
| Charles (Rapoport, 1989): 14-year-old with washing rituals; clomipramine helped, but tolerance and relapse after about a year                                                                                                                                                | Learn it |
| MOCI: 30 true/false self-report items; checking, washing, slowness, doubting; total 0–30, high score suggests OCD; about 5 minutes                                                                                                                                           | Learn it |
| Y-BOCS: symptom checklist plus 10 severity items (time, interference, distress, resistance, control, for obsessions and for compulsions), each 0–4 (none, mild, moderate, severe, extreme); total 0–40; 16+ clinically significant; semi-structured interview or self-report | Learn it |
| Biochemical: low serotonin (and high dopamine). Genetic: runs in families, Lewis (1936) 37% with a parent and 21% with a sibling with OCD; MZ concordance higher than DZ                                                                                                     | Learn it |
| Cognitive: thinking errors, inflated responsibility (Salkovskis, 1985), thought-action fusion. Behavioural: compulsion negatively reinforced by anxiety relief. Psychodynamic: anal-stage fixation, id against superego, compulsions as defences                             | Learn it |
| SSRIs block serotonin reuptake, so more serotonin stays in the synapse; higher doses than for depression; several weeks to work; Soomro et al. (2008): 17 trials, 3097 patients                                                                                              | Learn it |
| ERP: hierarchy, exposure to the trigger, compulsion prevented, anxiety habituates. Lehmkuhl et al. (2008): Jason, 12, autism and OCD, ten 50-minute sessions over 16 weeks, Y-BOCS 18 to 3                                                                                   | Learn it |
| Lovell et al. (2006): 72 outpatients, aged 16–65, Y-BOCS 16+; 10 weekly ERP sessions, face to face (1 hour) or telephone (2 face to face, 8 calls up to 30 minutes); Y-BOCS, BDI, satisfaction; follow-up 1, 3 and 6 months; no significant difference (–0.55 at 6 months)   | Learn it |
| BDI: 21 items, each 0–3, maximum 63                                                                                                                                                                                                                                          | Learn it |
| Percentage change = $\frac{\text{new} - \text{old}}{\text{old}} \times 100$                                                                                                                                                                                                  | Learn it |

## How to do it

We have tagged 39 questions on this topic, from 2021 to 2026 (Papers 3 and 4; 29 different questions, as variants repeat them). 8 of them have parts of more than one type, so the counts add up to 47. Questions before 2024 use the older syllabus (hoarding, body dysmorphic disorder): learn the current content and use those questions for the skill they test.

| Question type                                                  | Questions |
|----------------------------------------------------------------|-----------|
| Describe and evaluate a part of the topic (essay, named issue) | 10        |
| Design or plan a study on OCD                                  | 7         |

| Question type                                                          | Questions |
|------------------------------------------------------------------------|-----------|
| "To what extent do you agree" evaluative essay                         | 5         |
| Describe, apply or compare explanations of OCD                         | 5         |
| Define obsessions and compulsions, give types and examples             | 5         |
| Apply ICD-11 diagnostic criteria to a person                           | 4         |
| Outline and evaluate measures and diagnosis (Y-BOCS, MOCI, interviews) | 4         |
| Explain or apply a treatment (SSRIs, ERP, CBT) in short answer         | 4         |
| Recall details of Lovell et al. (2006) in short answer                 | 3         |

## 1. Describe and evaluate a part of the topic (essay, named issue) (10 questions)

Paper 3, part (a) **describe** (6 marks; 8 before 2024) and part (b) **evaluate** (10 marks) with a **named issue**. The part can be the treatments, the explanations, the diagnosis and measures, or Lovell et al. alone.

1. **(a) Describe every named item.** If the question names two (e.g. SSRIs and ERP), describing one only is capped. For a treatment, say **how it reduces symptoms**: SSRIs block reuptake, more serotonin, less anxiety, less need for the compulsion; ERP exposes, blocks the ritual, anxiety habituates. Add the study with numbers (Jason's Y-BOCS 18 to 3; Lovell's 72 patients and no significant difference at 6 months).
2. Keep side effects and other evaluation out of (a); they earn nothing there (June 2023 report).
3. **(b) Go issue by issue, the named issue first.** For each issue, apply it to **each** item and explain why, with evidence from (a). Use the table above.
4. **Named issues you have met:** use of children (Jason was 12; Charles 14), reliability, reductionism versus holism, determinism versus free will, qualitative and quantitative data.
5. End with a judgement: which treatment or explanation holds up best, and for whom.

### Variations:

- **Lovell et al. alone:** (a) aim, sample, groups, measures, results; (b) reliability (same therapy, measures and timings for both groups), cultural differences (UK), motivation, self-report validity.
- **Characteristics** (old syllabus): types, Charles, MOCI and Y-BOCS; for qualitative and quantitative data, use examples from your part (a) (Y-BOCS totals against Charles's case).

## 2. Design or plan a study on OCD (7 questions)

Paper 4. Since 2024: (a) a plan [10] with the specific features of the named method; (b)(i) the psychology it is based on [4]; (b)(ii) how two features of it shaped the plan [4]; (c) reasons, a weakness and the type of data, each about **your** plan. Earlier papers had (a) [10] and (b) psychological and methodological evidence [8], with only 5 marks if one kind is missing. See the research-methods note for each method's features.

1. **Do what the question names**: an observation means an observation, not a questionnaire; people with **OCD**, not impulse control disorders (March 2023 report); the comparison asked for (women against men), not some other one (June 2021 and June 2023 reports).
2. **Most common compulsion (observation)**: a structured observation with **behavioural categories** taken from the common compulsions (checking, washing or cleaning, counting, ordering, repeating), a tally of each, two observers for **inter-rater reliability**, a sample of diagnosed patients with consent (e.g. at a clinic, overt), and quantitative data (frequencies, a mode).
3. **(b)(i)**: the **compulsions** behind your categories, not the whole Charles story (November 2021 report).
4. **Treatment studies (SSRIs, telephone CBT)**: patients randomly allocated to conditions, the DV measured with the **Y-BOCS** before and after, with follow-ups (not just "ask the person", June 2021 report); base it on Lovell et al. or the SSRI evidence, and say how long SSRIs take to work (November 2022 report). People with OCD live at home, not in hospital.
5. **Explain each feature**, don't just name it ("independent groups, so no patient receives both therapies"), and **link** the psychology to your plan rather than evaluating the design (June 2023 report).

### 3. "To what extent do you agree" evaluative essay (5 questions)

Old Paper 4, 12 marks: a strong claim to debate. Argue **both sides** with research, then reach a **reasoned conclusion**. A descriptive essay scores almost nothing (June 2022 and November 2021 reports).

- **"Biomedical treatment is the only solution" / "is irrelevant"**: for drugs: quick, easy, the patient can be passive, SSRIs beat placebo in many trials, and they help with the depression many people with OCD also have. Against: they treat symptoms, not the cause; side effects; relapse when stopped (Charles); CBT and ERP give lasting change (Lovell, Jason). Give **both** treatments real weight (March 2023 report).
- **"Psychometric measures give no useful information"**: useful: the MOCI shows which types of symptom; the Y-BOCS measures severity and tracks change, as in Lovell. Not useful: self-report bias, no reasons, a number misses the person's experience; an interview adds depth.
- **"Charles can be generalised to everyone"**: for: many people with OCD share his rituals, and drugs used with him help others. Against: one boy, his own history; everyone's OCD differs (June 2021 report).

### 4. Describe, apply or compare explanations of OCD (5 questions)

- **"Suggest two different explanations" for a person** (4 marks): for each, name the explanation (1) and link a detail of it to the person (1). Choose ones the stem supports, e.g. a parent with similar habits suggests **genetic** (inherited, OCD runs in families, Lewis's figures) and **behavioural** (rituals praised or copied; doing them relieves anxiety, negative reinforcement); or **psychodynamic** (strict toilet training, anal fixation). For biochemical, say low serotonin or high dopamine, not low dopamine.
- **Describe the psychodynamic explanation** (4 marks): anal stage, conflict over toilet training, **fixation**, anally retentive, id against superego, compulsions as defences. The anal stage and fixation must be there.
- **One similarity and one difference** between two explanations (6 marks, levels): pick a clear point and explain it for **both**. Psychodynamic and genetic: both **deterministic** (the person controls neither genes nor childhood stages); both involve **parents** (genes passed on; parenting style). Different: genetic is **nature**, psychodynamic mostly **nurture**; genetic evidence is objective, psychodynamic is interpretation.

- **Situational explanation** (2 + 2): behaviour caused by the environment the person is in (1), e.g. washing is repeated because it brings relief from anxiety, negative reinforcement (1). A weakness, explained: **reductionist** (ignores genes and biochemistry), **deterministic**, or **individual differences** (many people feel relief after cleaning and never develop OCD).

## 5. Define obsessions and compulsions, give types and examples (5 questions)

2 marks each: the definition (1) and an example (1).

- **Obsession**: a persistent, recurring, intrusive thought that causes anxiety; e.g. fear of contamination, fear of harming someone, the need for symmetry. "Thoughts" alone scores 0.
- **Compulsion**: an act, physical or mental, that is repeated in a fixed way to bring anxiety down; e.g. repeated checking of locks, excessive washing, counting, hoarding. "Behaviours" alone scores 0.
- **"Two common obsessions"**: give **thoughts**, not compulsions, and not types of disorder such as hoarding (March 2021 report).
- **Old syllabus, BDD compulsions**: mirror checking, camouflaging a feature with clothes or make-up, excessive grooming, comparing appearance with others, seeking cosmetic surgery.

## 6. Apply ICD-11 diagnostic criteria to a person (4 questions)

4 marks. Use the person's details for each criterion; restating "obsessions and compulsions" from the question earns nothing.

1. **Pick out the obsession** from the stem and say why it is one (persistent, intrusive, irrational).
2. **Pick out the compulsion** (repetitive, by rules) and say it is done to **reduce the anxiety** from the obsession, which soon returns.
3. **Time**: work out how long it takes (more than an hour a day counts).
4. **Distress or impairment**: lost sleep, missed work or school, avoiding friends.

### Variations:

- **"Why might a parent think a child has OCD"**: other rituals besides washing (counting, checking, mental acts), time taken, withdrawal from family, each linked to the child.
- **"How will a doctor decide"**: a **clinical interview** using **ICD-11** (name it for full marks) **plus** a measure explained, e.g. the Y-BOCS (semi-structured, 0–40, 16+ suggests OCD) or the MOCI (30 true/false items). Just naming a measure earns only 1.

## 7. Outline and evaluate measures and diagnosis (Y-BOCS, MOCI, interviews) (4 questions)

- **Why a diagnosis may be wrong** (2): the reason (1) plus why it happens, applied to the person (1): embarrassment or social desirability leads to under-reporting and a **type 2 error**; poor insight; the MOCI not covering their type of OCD; a biased doctor causing a **type 1 error**. Give the reason **and** why it leads to the wrong diagnosis (March 2026 report).

- **Why an interview may not help** (2): the person is ashamed of a specific symptom and hides it; cannot put thoughts into words; a parent is present; thinks the thoughts are normal.
- **The Y-BOCS item scale** (2): 5 points, **0–4**, none to extreme. The number of items and the 0–40 total earn nothing here.
- **Testing reliability: test-retest** (give the Y-BOCS to the same patients twice, a short time apart, and correlate the scores) or **split-half** (correlate scores on the two halves of the scale).
- **Testing validity: concurrent** (correlate Y-BOCS scores with another OCD measure, e.g. the MOCI or a clinician's diagnosis); **construct** (do the items match what OCD is?).
- **Strengths of psychometric tests or rating scales**: quantitative, so a person can be compared **over time** (did the score fall after treatment?) and **with others** or norms; items based on ICD features; standardised.  
**Weaknesses**: ignore what is unique about a person's OCD; no chance to explain feelings about their rituals; self-report bias.

## 8. Explain or apply a treatment (SSRIs, ERP, CBT) in short answer (4 questions)

**For a named person** (4 marks; capped at 2 without their details):

- **CBT**: explain OCD to them (psychoeducation: how their thought leads to their ritual); a homework diary of thoughts, rituals and feelings; challenge the belief and replace it with a realistic one, quoting both from their case; then reduce the ritual. ERP for them also earns full marks if it is about the person (March 2025 report). Searching for past causes earns nothing.
- **ERP**: identify the obsession and compulsion; gradually reduce or block the ritual in the trigger situation; anxiety rises at first, then falls when the feared event doesn't happen; the obsession weakens because the fear was not confirmed.
- **A weakness of ERP** (2): very stressful at first, so some quit; does not tackle any underlying cause; takes many sessions (time and cost).

**Paper 4 parts:**

- **How SSRIs work** (2): block **reuptake**, so serotonin levels **rise**, which reduces anxiety. Not "block serotonin" and not lower serotonin; and talk about OCD, not depression (June 2021 and June 2023 reports).
- **An ERP case study** (4): **Lehmkuhl et al.**, Jason; not Charles (no ERP) or Saavedra and Silverman (no OCD) (June 2023 report).
- **Strengths and weaknesses of drugs, with a conclusion** (5): two of each **about OCD** ("easy to take: a patient swallows an SSRI tablet instead of facing their fear of germs"), then a conclusion that reaches a decision, not a summary.

## 9. Recall details of Lovell et al. (2006) in short answer (3 questions)

Precise recall, usually 2 marks a part.

- **Measures:** self-report Y-BOCS (10 items, 0–4, 0–40, bands) and the BDI (21 items, 0–3, max 63). The Y-BOCS was self-report here, so don't call it an interview. Saying what a measure measures earns nothing on its own: give its features.
- **Inclusion:** OCD diagnosis; Y-BOCS 16+; age 16–65. **Exclusion:** obsessional slowness, organic brain disease, substance misuse, severe depression or suicidal intent, on medication under 3 months.
- **No control group:** the aim was to see whether telephone CBT is as good as face to face, so both groups were treated; a no-treatment group would also have to meet the same criteria and be left untreated.
- **Strengths of excluding people:** protects them from harm (a short phone therapy may not suit someone suicidal or very slow); makes sure a change comes from the therapy and not from a new drug.
- **Describe the study, with a strength and a weakness:** give the groups, sessions, measures and results; describe Lovell, not Lehmkuhl or Rapoport (March 2021 report). For a weakness such as generalisation, say where the participants came from and why that matters.

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## Worked examples

### Example 1

Tomas, aged 19, keeps getting vivid images of his flat burning down while he is out. Before leaving, he checks every plug socket and the cooker in a set order, six times each, and if he loses count he starts again from the beginning. This takes up to 90 minutes each morning, and he has missed several lectures.

(a) Explain how Tomas meets the ICD-11 diagnostic criteria for OCD. [4]

(b) Tomas's doctor asks him to complete the MOCI. Explain one limitation of using the MOCI to assess Tomas. [2]

**(a)** Tomas has an obsession: the image of his flat burning down returns again and again against his will and makes him anxious, even though the danger is tiny **(1)**. He has a compulsion: he checks the sockets and cooker in a fixed order, six times, and restarts if interrupted, which follows rigid rules **(1)**. The checking is done to reduce the anxiety the image causes **(1)**. It is time-consuming, up to 90 minutes a day, which is more than the hour ICD-11 gives as a guide, and it impairs his education because he misses lectures **(1)**.

**(b)** The MOCI only asks true/false questions about kinds of symptom, so it cannot show how severe Tomas's checking is **(1)**: a "true" to an item about checking things several times would look the same whether he checks for 5 minutes or 90 minutes a day, so the doctor would need the Y-BOCS or an interview to judge how much it impairs his life **(1)**.

### Example 2

Ines believes that if she does not tap each doorframe an even number of times when walking through, her younger brother will have an accident. She often taps a frame dozens of times before she feels safe.

(a) Explain Ines's behaviour using the cognitive explanation of OCD. [2]

(b) Suggest how exposure and response prevention (ERP) could be used to treat Ines. [4]

(a) Ines shows a thinking error, an inflated sense of responsibility: she believes her brother's safety depends on her tapping, so an ordinary passing thought about an accident feels like a warning she must act on (1). Tapping neutralises the thought and lowers her anxiety, so she never tests the belief and it stays strong (1).

(b) The therapist first helps Ines name her obsession (that her brother will be hurt) and her compulsion (tapping doorframes an even number of times) and builds a hierarchy, from walking through a door at home with her brother safely in the room, up to walking through many doors while he is out (1). At each step she walks through without tapping, or taps an odd number of times, and is helped to resist the urge (1). Her anxiety rises sharply at first, but if she stays in the situation it falls on its own (habituation), so the compulsion is no longer needed to make the anxiety go away (1). Because her brother comes to no harm, the belief that tapping protects him is not confirmed, and the obsession weakens (1).

### Example 3

(a) Describe the biochemical and genetic explanations of obsessive-compulsive disorder. [6]

(b) Evaluate the biochemical and genetic explanations of obsessive-compulsive disorder, including a discussion of nature versus nurture. [10]

(a) *Biochemical.* OCD is linked to low activity of serotonin, a neurotransmitter that helps regulate mood and anxiety, and possibly to high dopamine activity, which may drive repetitive behaviour. With too little serotonin activity, intrusive thoughts may cause more anxiety than normal, making compulsions likely. The evidence is that SSRIs, which block serotonin reuptake so more stays in the synapse, reduce symptoms: a review of 17 trials with 3097 patients found SSRIs better than a placebo, and Charles improved on clomipramine, which also raises serotonin.

*Genetic.* A vulnerability to OCD is inherited, so it runs in families. Lewis (1936) found that 37% of patients with OCD had a parent and 21% a sibling with the disorder. Identical twins are more often both affected than non-identical twins, which suggests genes play a part. Many genes, including some that affect serotonin, each seem to add a small risk.

**Why it reaches the top level:** both explanations are described accurately, with the mechanism, correct terms and evidence for each.

(b) *Nature versus nurture (the named issue).* Both explanations are on the nature side: OCD comes from brain chemistry or inherited genes. The family evidence cannot separate nature from nurture, though: a child whose parent has rituals may copy them and be rewarded for them, which is the behavioural explanation. Twin studies help, because identical twins share more genes but similar upbringings, yet their concordance is not 100%, so the environment must also play a part. A diathesis-stress view, an inherited vulnerability triggered by experience, fits the evidence best.

*Reductionism.* Both explanations reduce a complex disorder to chemicals or genes, ignoring the thinking errors such as inflated responsibility that the cognitive explanation shows. This matters for treatment: SSRIs do not help every patient, and symptoms often return when the drug is stopped, as Charles's did.

*Cause and effect, and usefulness.* Low serotonin may result from long-term anxiety rather than cause it, so SSRIs helping does not prove the cause. Even so, the biochemical explanation has led to drugs that help many patients quickly.

**Why it reaches the top level:** issue by issue, the named issue first and in depth, both explanations considered in each issue with evidence from (a), and a balanced judgement.

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## Common mistakes

- **Confusing obsessions and compulsions:** "obsessed with hand-washing" (November 2022 report), or giving compulsions or hoarding when asked for obsessions (March 2021 report).
- **Vague definitions:** "thoughts" or "behaviours" alone scores nothing; say persistent, intrusive, repetitive, rigid rules.
- **Examples from other disorders:** impulse control disorders (kleptomania, gambling) are not OCD, and phobias or addictions earn nothing in an OCD answer (June 2023 and November 2022 reports).
- **Getting SSRIs backwards:** they block **reuptake** and **raise** serotonin; they don't lower serotonin or "block serotonin" (June 2021 and June 2023 reports). Write about OCD, not depression.
- **Mixing up the case studies:** Charles had OCD but no ERP; Saavedra and Silverman's boy had ERP but not OCD; Jason (Lehmkuhl et al.) is the ERP case (June 2021 and June 2023 reports). For Lovell, don't describe Lehmkuhl or Rapoport (March 2021 report).
- **Evaluation in the wrong part:** side effects in a "describe" part earn nothing, and nor do long lists of symptoms when treatments are asked for (June 2023 report).
- **Many issues for one item** instead of each issue applied to every item, or naming an issue (reductionist, deterministic) without saying why; determinism is not reductionism (June 2021 and June 2023 reports).
- **Qualitative and quantitative data with no example** from your part (a) (November 2022 report).
- **Not engaging with the person in the stem:** a general account of CBT without them (March 2025 report).
- **Design questions that change the question:** no observation when one is named, the wrong comparison, or effectiveness "measured" with no measure such as the Y-BOCS (March 2023, June 2021 and November 2022 reports).

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## How to get the marks

- **"Identify", "give":** short exact facts (a criterion, a measure, a number).
- **"Outline"** (2 marks): the point plus a feature or example.
- **"Explain" or "suggest"** (2 marks a point): the point (1) applied to the person, measure or study (1).
- **Person questions:** use their name, their obsession and their ritual in every step; quote the thought you would challenge.
- **"Describe" essays:** every named treatment or explanation, with terms (reuptake, negative reinforcement, fixation, habituation, inflated responsibility) and **how** it causes or reduces OCD.

- **"Evaluate"** (10 marks): issue by issue, named issue first, every item compared within each issue, context from part (a), a judgement.
- **Measures**: numbers earn marks (30 true/false items; 10 items scored 0–4, total 0–40; 16+).
- **"Conclusion"**: a decision reached by reasoning, not a summary.

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## Quick check

1. A patient's ten Y-BOCS item scores are 3, 2, 3, 3, 2, 3, 2, 3, 2, 3. What is the total, and which severity band is it in?
2. Say whether each is an obsession or a compulsion: (a) silently repeating a prayer seven times; (b) a constant fear of having run someone over while driving; (c) rearranging the cushions until they are exactly symmetrical; (d) a sudden, unwanted image of shouting something offensive in a quiet library.
3. Jason's Y-BOCS score fell from 18 to 3. Calculate the percentage decrease to 1 decimal place.
4. In Lovell et al. (2006), how many minutes of therapist contact did a patient get in each group, assuming every session ran its full length? By what percentage was the telephone group's total lower?
5. A man with OCD feels calmer every time he finishes checking the windows. Which explanation does this support, and what is the process called?

## Answers

1.  $3 + 2 + 3 + 3 + 2 + 3 + 2 + 3 + 2 + 3 = 26$ : **severe** (24–31).
2. (a) **Compulsion** (a mental act). (b) **Obsession**. (c) **Compulsion**. (d) **Obsession** (an intrusive image).
3.  $\frac{18 - 3}{18} \times 100 = 83.3\%$ .
4. Face to face:  $10 \times 60 = 600$  minutes. Telephone:  $2 \times 60 + 8 \times 30 = 360$  minutes.  $\frac{600 - 360}{600} \times 100 = 40\%$  lower.
5. The **behavioural** explanation (operant conditioning): the relief from anxiety is **negative reinforcement**, which makes checking more likely next time.

## Past questions to try

- 9990/33/O/N/24 Q4: essay describing and evaluating Lovell et al., with reliability.
- 9990/33/M/J/24 Q1: how a person meets the ICD-11 criteria for OCD.
- 9990/32/F/M/24 Q3: ERP for a person's checking compulsion, and one weakness.
- 9990/42/M/J/24 Q1: Lovell et al.'s inclusion and exclusion criteria.