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A Culturally Sensitive Behavioural Screening Tool For Obsessive-Compulsive Traits: Comprehensive On Malhotra Obsessive Compulsive Scan (MOCS)

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Abstract

The Malhotra Obsessive Compulsive Scan (MOCS) is a newly developed clinician-rated behavioural observation tool created to identify subtle obsessive-compulsive traits as they naturally unfold within therapeutic, clinical, and counselling settings. Unlike conventional self-report inventories which rely heavily on an individual's insight, self-awareness, and willingness to disclose symptoms MOCS focuses on observable behavioural markers that frequently remain unnoticed or unreported. These include reassurance-seeking, perfectionistic hesitation, excessively crowded or margin-less writing, rigid communication patterns, over-apologizing, and difficulty being interrupted. Such behaviours, while strongly associated with obsessive-compulsive tendencies, are often minimized, masked, or culturally normalized in the Indian context where politeness, discipline, and meticulousness may be perceived as positive traits rather than indicators of underlying anxiety or compulsive functioning.

By capturing these subtle patterns through structured clinician observation, MOCS aims to bridge a critical gap in OCD assessment, particularly for high-functioning individuals, adolescents, and clients whose symptoms manifest more behaviourally than cognitively. The tool offers an ecologically valid and culturally sensitive method for early detection, differential diagnosis, and monitoring of obsessive-compulsive traits. Moreover, MOCS provides clinicians with actionable insights to tailor therapeutic interventions such as Cognitive Behavioural Therapy (CBT), Exposure and Response Prevention (ERP), mindfulness-based approaches, and Subconscious Energy Healing Therapy (SEHT).

Designed with the Indian psychosocial landscape in mind, MOCS holds promise for improving diagnostic accuracy, reducing under-identification of obsessive-compulsive tendencies, and supporting standardised assessment practices. Ongoing standardisation efforts aim to validate its psychometric robustness and enhance its applicability across diverse Indian populations.

Keywords: Obsessive-Compulsive Traits, Behavioural Observation, Clinical Assessment, Cultural Psychopathology, MOCS (Malhotra Obsessive Compulsive Scan)

Introduction

Obsessive–Compulsive Disorder (OCD) is a chronic and often debilitating mental health condition marked by intrusive, distressing thoughts (obsessions) and repetitive, ritualistic behaviours or mental acts (compulsions) performed to reduce anxiety (American Psychiatric Association, 2013). Although well-established diagnostic and assessment tools exist, such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), many of them rely heavily on the client's ability to identify, label, and report internal obsessions and compulsions (Goodman et al., 1989). Insight, however, is frequently limited in individuals with OCD, especially those whose compulsive patterns manifest through interpersonal behaviours such as reassurance-seeking, perfectionistic checking, guilt-driven apology, or hyper-responsibility (Abramowitz & Jacoby, 2015).

In collectivistic cultures such as India, additional challenges arise. Several behaviours characteristic of obsessive tendencies such as excessive politeness, repeated reconfirmation, meticulousness, over-apology, or rigid adherence to correctness are socially rewarded and culturally embedded (Reddy & Rao, 2018). As a result, individuals may not view these actions as pathological, and clinicians may unintentionally misinterpret such behaviours as normative rather than symptomatic (Khandelwal & Reddy, 2019). These sociocultural dynamics contribute to underdiagnosis, late detection, or misclassification of OCD-related traits, particularly among adolescents and adults who demonstrate subtle or subclinical obsessive patterns.

To address this gap, the Malhotra Obsessive Compulsive Scan (MOCS) was conceptualized as a clinician-rated observational tool focused on identifying naturalistic, session-based behaviours indicative of obsessive–compulsive tendencies. Unlike traditional self-report instruments, MOCS emphasizes observable behavioural markers such as crowded writing, perfectionistic hesitation, compulsive apologizing, excessive reassurance-seeking, and difficulty tolerating interruptions patterns that often appear spontaneously during clinical interactions. These observable markers may offer greater cultural validity and clinical accuracy, particularly in Indian settings where internal obsessive distress is frequently masked by socially sanctioned behavioural patterns.

Epidemiological studies indicate that OCD is a significant mental health concern in India, with prevalence estimates ranging from 0.6% to 3.3% in community and youth samples (Sharma et al., 2018; Subramaniam et al., 2019). Subclinical or "subthreshold" obsessive–compulsive symptoms are even more common, affecting up to 8–12% of adolescents and young adults (Rane et al., 2015). Such subclinical forms are associated with elevated psychological distress, suicidality, interpersonal difficulties, and functional impairment, despite not meeting full diagnostic criteria (Fineberg et al., 2015). Indian clinical studies highlight culturally influenced symptom profiles. For instance, contamination fears and washing compulsions remain common, but culturally sanctioned rituals often blur the line between normative religious practices and pathological compulsions (Khandelwal & Reddy, 2019). Additionally, Indian samples show elevated checking, repeating, and responsibility-driven behaviours, which may be reinforced by cultural expectations around duty, morality, and family roles (Reddy & Rao, 2018). These findings underscore the importance of assessment tools capable of identifying functional impairment even when behaviours appear socially normative, gendered, or culturally reinforced.

Recent clinical observations and emerging evidence have shown that obsessive–compulsive behavioural patterns are frequently present in clients with narcissistic personality traits, particularly those identified through the Narcissistic Personality Pattern Test (NPPT) and the PGI N2 (PGI Health Questionnaire N2). Although Narcissistic Personality Disorder (NPD) and OCD are distinct diagnostic entities, their behavioural overlap especially in Indian clinical populations is becoming increasingly evident. Many individuals with narcissistic traits exhibit subtle compulsive characteristics such as rigid perfectionism, control-oriented interpersonal styles, intolerance for error, heightened self-monitoring, and repetitive reassurance-seeking related to self-image maintenance.

In clinical practice, the correlation between MOCS scores, NPPT narcissistic pattern elevations, and N2 indicators has revealed meaningful patterns. These tools together uncover how clients with narcissistic tendencies often display obsessive–compulsive behavioural styles that are not captured by traditional OCD tools alone. For instance, NPPT may highlight grandiosity or vulnerability, while MOCS captures the behavioural compulsions such as repetitive justification, over-detailing, environmental control, or the compulsive need to appear "correct" that operate beneath the narcissistic defence system. Similarly, N2 markers such as guilt proneness, interpersonal tension, or anxiety-driven control complement MOCS findings, allowing a more integrated understanding of the client's behavioural functioning.

This cross-tool correlation supports the clinical observation that OCD-patterned behaviours often co-exist within narcissistic presentations, particularly in high-functioning clients who mask internal distress through rigid, perfectionistic, or overly controlled behaviours. Incorporating MOCS alongside NPPT and N2 therefore enhances diagnostic clarity, identifies comorbid obsessive patterns in NPD presentations, and offers a richer, multidimensional assessment of personality and behavioural rigidity.

Limitations of Traditional Self-Report Measures Such as Y-BOCS

Although the Y-BOCS is considered the gold standard for assessing OCD severity, several limitations reduce its effectiveness in culturally diverse contexts:

Dependence on Insight and Self-Awareness

Many individuals with OCD have difficulty recognizing their behaviours as excessive or unreasonable. Limited insight reduces the accuracy of self-report measures (Eisen et al., 2013).

Under-reporting Due to Shame, Embarrassment, or Normalization

Self-report formats rely on clients consciously acknowledging taboo thoughts (e.g., sexual, aggressive obsessions). Cultural stigma often leads to minimization or denial (Fontenelle et al., 2010).

Cultural Misinterpretation of Compulsions

In countries like India, perfectionistic behaviours, repeated apology, reassurance-seeking, or excessive neatness may be perceived as positive personal traits rather than symptoms (Khandelwal & Reddy, 2019).

Psychometric Gaps for Subclinical Symptoms

Y-BOCS was designed to measure severity after diagnosis. It may not detect subthreshold obsessive traits or interpersonal manifestations of compulsions (Storch et al., 2010).

Measurement Bias in Non-Western Populations

Cross-cultural studies show that Y-BOCS factor structures vary across demographics. Certain items, such as "resistance" or "control over obsessions," do not perform uniformly across cultural groups (Matsunaga et al., 2002). Because traditional scales emphasize internal symptom endorsement rather than observable behaviour, subtle compulsive tendencies especially socially accepted ones often remain undetected.

Cultural Influences on OCD Expression

A substantial body of literature highlights that while the core phenomenology of OCD is universal, its expression is significantly shaped by cultural meanings, social expectations, and religious norms (Chakraborty & Basu, 2010).

Key cultural influences in India include:

Collectivism and Hyper-Responsibility: Individuals may display excessive responsibility for family harmony or outcomes, aligning with compulsive moral scrupulosity (Reddy & Rao, 2018).

Religious and Ritual Practices: Repetitive cleaning, ritualistic bathing, or prayer practices may mask pathological compulsions (Chakraborty & Basu, 2010).

Gendered Expectations: Women may exhibit culturally reinforced orderliness or moral purity, while men may demonstrate checking or perfectionistic control behaviours (Devi et al., 2018).

These cultural factors complicate the detection of OCD, particularly when symptoms manifest interpersonally (e.g., chronic apologizing) or behaviourally (excessive neatness, hesitation, correction).

Need for an Observational Assessment Tool

Given these limitations, researchers have increasingly advocated for ecologically valid, behaviour-based, and culturally sensitive assessment approaches (Abramowitz & Jacoby, 2015). Observational tools commonly used in autism, ADHD, feeding disorders, and personality assessments allow clinicians to document naturally occurring behavioural patterns that clients may not consciously report.

For OCD specifically, there is a widening gap:

- No standardized observational tool exists for identifying obsessive interpersonal or behavioural markers.
- Existing tools focus on symptom severity, not early detection or cultural nuance.
- Subclinical OCD and culturally masked obsessive traits remain largely unassessed.
- The Malhotra Obsessive Compulsive Scan (MOCS) bridges this gap by focusing on observable, session-based behaviours long noted by clinicians but rarely formalized in assessment frameworks.

These include:

- Repeated reassurance or reconfirmation
- Excessive apology or guilt expressions
- Perfectionistic writing or hesitation
- Over-correction or intolerance to mistakes
- Visible distress when interrupted
- Rigid behavioural patterns during sessions

Such markers provide richer insight into obsessive–compulsive tendencies that may not appear on traditional scales like the Y-BOCS.

Methodology

Research Design

A multi-phase, mixed-methods scale development design was employed to develop and validate the Malhotra Obsessive Compulsive Scan (MOCS). The process followed internationally accepted guidelines for behavioural assessment tool construction, including qualitative item generation, expert review, pilot testing, and quantitative psychometric evaluation (DeVellis, 2016; Boateng et al., 2018).

Phase 1: Item Generation

1.1 Conceptual Development

Item creation was grounded in:

Indian cultural expressions of OCD

Clinically documented subtle obsessive behaviours

Literature on reassurance-seeking, perfectionism, cognitive rigidity, and environmental control

Gaps in self-report instruments like the Y-BOCS, which focus on internal symptoms rather than live behaviour

1.2 Expert Interviews

Semi-structured interviews with clinical experts (5 psychologists, 3 psychiatrists, 4 counsellors) generated an initial list of 26 subtle behaviours frequently seen but often dismissed as cultural norms.

1.3 Item Refinement

Items were selected if they were:

Observable without prompting

Culturally meaningful in India

Clinically relevant for OCD

Presentable in a 20-minute interaction

This yielded the final 10-item checklist.

Phase 2: Content & Face Validity

2.1 Content Validation

A panel of eight OCD experts evaluated each item for:

Clinical relevance

Clarity

Observability

Cultural fit

Content Validity Index (CVI) thresholds:

I-CVI ≥ 0.78

S-CVI ≥ 0.85

All items met or exceeded standards after minor refinements.

2.2 Face Validity

Three clinicians evaluated usability, cultural appropriateness, and interpretability. All confirmed that MOCS appears intuitive, culturally sensitive, and feasible in real sessions.

Phase 3: Pilot Study

3.1 Participants

A purposive sample of 30 clients aged 16–45 from clinical and counselling settings participated.

3.2 Procedure

A 20-minute semi-structured conversation was conducted.

Clinicians rated behaviours on the MOCS (0–3 scale).

No direct OCD questions were asked to maintain naturalistic observation.

Qualitative notes were recorded for refinement.

3.3 Outcomes of Pilot

Items showed good variability, clear observability, and cultural fit. No items were removed.

Phase 4: Large-Scale Validation

4.1 Participants

A planned sample of N = 150 individuals across diverse settings (clinical, counselling, community). The sample includes three groups:

Diagnosed OCD group (n = 50)

Anxiety/related disorders without OCD (n = 50)

Non-clinical control group (n = 50)

4.2 Instruments for Validation

To assess psychometric validity, MOCS scores will be compared only with:

Yale–Brown Obsessive Compulsive Scale (Y-BOCS)

Gold standard for OCD symptom severity

Used as the primary criterion and convergent validity measure

4.3 Data Collection Procedure

Each participant undergoes a clinical session; MOCS is rated by the clinician.

Separately, a trained psychologist administers the Y-BOCS.

The two assessments are conducted independently to avoid bias.

Phase 5: Reliability Assessment

5.1 Internal Consistency

Cronbach's alpha will be calculated.

Benchmark: $\alpha \geq 0.70$

5.2 Inter-Rater Reliability

Two trained raters will observe 20% of sessions independently.

Statistic: Intraclass Correlation Coefficient (ICC)

Cut-off: ICC ≥ 0.75

5.3 Test–Retest Reliability

40 participants will be reassessed after 7–10 days.

Expected correlation: $r \geq 0.70$

Phase 6: Validity Assessment

6.1 Convergent Validity

Correlation of MOCS scores with Y-BOCS total scores.

Expected relationship:

Moderate to strong positive correlation (r = .40–.70)

6.2 Known-Groups Validity

ANOVA will compare mean MOCS scores between:

OCD group

Non-OCD anxiety group

Non-clinical group

Expected outcome:

OCD > Anxiety > non-clinical

Phase 7: Ethical Considerations

Informed consent

Confidentiality and anonymity throughout

No direct probing of OCD symptoms to avoid distress

Right to withdraw at any time

Phase 8: Data Analysis Plan

Statistical analyses will be conducted using SPSS or R.

Analyses include:

Descriptive statistics

Cronbach's alpha

ICC for inter-rater reliability

Pearson correlation with Y-BOCS

ANOVA for group differences

Post-hoc tests

Factor analysis

Significance: $p < .05$

Why MOCS is Needed

1. OCD Often Goes Unnoticed in India

People with OCD-like tendencies may:

- Over-apologize due to cultural conditioning
- Seek repeated reassurance as politeness
- Maintain excessive order as discipline
- Narrate excessive details because "details matter"
- Hesitate before responding due to fear of being wrong
- Thus, pathology hides behind cultural behaviour.

MOCS helps clinicians differentiate:

Cultural behaviour

vs.

Pathological obsessive-compulsive patterns

2. Self-report OCD assessments are not enough

Most OCD tools rely on:

Self-awareness

Understanding of symptoms

Willingness to disclose

However, high-functioning OCD clients often do not understand their compulsive patterns or may intentionally mask them.

MOCS bypasses insight entirely because it is:

- Clinician-rated
- Observation-based
- Captures implicit behaviour naturally

3. OCD Behaviour Appears in Interactions, Not Only Thoughts

Obsessive tendencies often manifest through:

- Body language
- Writing patterns
- Speech flow
- Conversational rigidity
- Difficulty stopping behaviour
- MOCS captures these subtle expressions.

Purpose of MOCS

MOCS is designed to identify subtle obsessive-compulsive traits through:

- Speech
- Body posture
- Writing style
- Reassurance-seeking
- Cognitive rigidity
- Control behaviour
- Interpersonal proximity

These indicators help reveal compulsive tendencies even when clients deny or minimize symptoms.

Nature of the Instrument (MOCS)

Type: Clinician-rated observational checklist

Population: Adolescents & adults (16+)

Time: 10–15 minutes observation

Setting: Counselling, clinical, educational, therapeutic

Developers: Malhotra & Puri (2025)

Behavioural Indicators in MOCS (10 Items)

- Reconfirmation-seeking
- Follow-up reassurance
- Difficulty being interrupted
- Environmental control
- Excessive proximity
- Inflexible communication
- Over-detailed narration
- Crowded writing
- Perfectionistic hesitation
- Excessive apology / guilt

Each rated on:

0 = Not observed

1 = Occasional

2 = Frequent

3 = Persistent

Scoring & Interpretation

The Malhotra Obsessive-Compulsive Scan (MOCS) uses a 10-item observational checklist rated on a 0–3 scale, yielding a total score between 0 and 30. The scoring is designed to reflect the frequency, intensity, and clinical significance of subtle obsessive–compulsive behavioural markers observed during a naturalistic session.

Score	Severity Level	Interpretation
0–6	Minimal	Behaviour falls within culturally normative patterns such as politeness, thoroughness, or attentiveness. No clinical concern.
7–13	Mild	Early/emerging obsessive traits. Behavioural tendencies show anxiety-driven patterns but may not cause significant impairment yet.
14–20	Moderate	Clearly identifiable obsessive–compulsive features. Behaviours interfere with flexibility, functioning, or emotional regulation.
21–30	Prominent	Strong indicators of obsessive–compulsive behavioural patterns. Comprehensive clinical evaluation is recommended.

Interpretation Note:

Because MOCS is culturally contextualized, a high score reflects behaviour beyond cultural expectations not polite communication, but compulsive patterns disrupting function or emotional comfort.

Why MOCS is Important for Clients

1. Early Detection

Many individuals in India experience subtle or subclinical OCD traits for years before seeking help, often due to:

Social normalization of perfectionism

High academic and familial expectations

Guilt-based conditioning and moral rigidity

Stigma associated with mental illness

MOCS identifies early behavioural warning signs, enabling:

- Prevention of symptom escalation
- Avoidance of chronic compulsive cycles
- Protection from academic, occupational, and relational impairment
- By detecting OCD traits before they crystallize into full-blown disorder, MOCS supports timely intervention.

2. Helps Clients Understand Hidden Patterns

Many clients remain unaware that their everyday habits are compulsive, not personality traits.

MOCS reveals patterns such as:

- Reassurance-seeking interpreted as care or politeness
- Over-detailing mistaken for thoroughness
- Perfectionistic hesitation perceived as self-discipline
- Guilt-driven apology seen as humility or good manners

Through feedback, clients often experience significant insight:

"I didn't know this was OCD-related this is just how I've always been."

MOCS helps clients reinterpret their behaviours through a psychological lens, improving self-awareness and motivation for therapy.

3. Better Therapeutic Planning

MOCS provides clinicians with specific behavioural targets, which makes treatment planning more individualized and effective.

Depending on the score profile, MOCS guides toward interventions such as:

- Cognitive Behavioural Therapy (CBT) for thought–behaviour restructuring
- Exposure and Response Prevention (ERP) for reassurance and compulsion reduction
- Mindfulness-based therapies for cognitive flexibility
- Subconscious Energy Healing Therapy (SEHT) for guilt and control patterns
- Behavioural modification for rigid communication or environmental control

MOCS clarifies which domain Reassurance, Control, or Cognitive Rigidity is most affected, leading to more precise therapy.

Why MOCS is Important for Clinicians

1. Detects OCD in High-Functioning Clients

Many high-functioning individuals (students, professionals, perfectionists) hide their internal distress.

They present well, communicate clearly, and appear composed, but their compulsions show in:

- Repeated validation checking
- Excessive apology
- Over-controlling environmental behaviour
- Rigid or overly detailed communication

MOCS highlights these "micro-compulsions" that standard interviews often miss.

2. Culturally Sensitive Assessment

Indian cultural practices often mask obsessive tendencies.

For example:

Reconfirming may appear as respect

Over-apologizing may seem polite

Perfectionism may be viewed as discipline

MOCS helps clinicians differentiate:

Cultural behaviour from

Compulsive behaviour

preventing both underdiagnosis and over pathologizing culturally normative traits.

3. Enhances Diagnostic Accuracy

Although MOCS is observational, it complements diagnostic assessments when paired with:

Y-BOCS

It reveals patterns that clients may not verbalize, improving diagnostic clarity and preventing misclassification.

4. Useful for Tracking Progress

MOCS can be administered:

At baseline

Mid-therapy

Post-therapy

Pre–post changes in:

- Reassurance patterns
- Perfectionistic hesitation
- Detail overloading
- Environmental control

provide objective indicators of therapeutic improvement, especially in clients who struggle to self-assess.

Planned Standardisation of MOCS

Sample Plan (N ≥ 150)

MOCS will be validated on a diverse population including:

- OCD-diagnosed clients
- Anxiety disorder clients
- Personality disorder clients (particularly OCPD traits)
- Non-clinical population (students, working adults)
- This allows robust norm development across clinical and non-clinical groups.
- Psychometric Properties to Be Established

1. Reliability

Inter-rater reliability ≥ .70

Ensures two clinicians observing the same session score similarly.

Test–retest reliability (14 days)

Measures stability of behavioural patterns.

Internal consistency (Cronbach's α ≥ .75)

Confirms that all 10 items reflect a unified behavioural construct.

2. Validity

Content validity- Established via multi-expert review

Concurrent validity - with Y-BOCS

3. Norm Development

Norms will be adjusted for:

Cultural communication patterns

Age differences (16–25, 26–40, 40+)

Gender norms

Educational level

This ensures culturally fair and accurate scoring.

Impact of MOCS on the Indian Population

1. Reduces Underdiagnosis

Indian clients commonly present with masked OCD:

Compulsions appear like personality traits

Anxiety-driven behaviours look culturally appropriate

Families normalize excessive responsibility

MOCS uncovers these hidden patterns, improving recognition and diagnosis.

2. Reduces Stigma

Unlike direct questionnaires, MOCS:

Does not require admitting taboo or embarrassing thoughts

Does not label or confront clients

Observes behaviour naturally and respectfully

Clients feel:

Safe

Non-judged

Understood

This increases engagement and reduces avoidance.

3. Enables Culturally Informed Treatment

MOCS recognizes cultural factors like:

Excessive politeness

Guilt conditioning from upbringing

High parental expectations

Perfectionism seen as discipline

Therapists can tailor interventions to match cultural family systems and identity.

4. Relevant in Schools, Colleges, and Clinics

MOCS can be applied in:

School counselling → early detection in adolescents

College mental health programs → identifying academic pressure-related OCD traits

Therapy settings → behavioural tracking

Community clinics → low-stigma assessments

Early identification leads to:

Reduced chronicity

Better long-term functioning

Improved emotional regulation and resilience

Conclusion

The Malhotra Obsessive Compulsive Scan (MOCS) represents a significant advancement in the culturally informed assessment of obsessive–compulsive traits within the Indian context. As an observation-based behavioural tool, MOCS addresses a longstanding gap in clinical assessment namely, the under-recognition of subtle, interpersonal, and culturally normalized obsessive patterns that often go unnoticed in traditional self-report frameworks. Indian cultural norms frequently reward traits such as excessive politeness, perfectionistic diligence, moral responsibility, and repeated reassurance.

While adaptive in many contexts, these behaviours can also serve as masking mechanisms for emerging or subclinical obsessive–compulsive tendencies. MOCS brings these overlooked behavioural cues into clinical focus by systematising the observation of naturalistic behaviours such as cognitive rigidity, hesitation patterns, over apologizing, environmental control, and the compulsive need for correctness.

By emphasizing real-time behavioural assessment rather than self-reported symptom awareness, MOCS offers clinicians a more ecologically valid and culturally sensitive method for detecting early obsessive patterns. This is particularly critical in India, where limited insight, stigma, and normalization of compulsive behaviours often delay diagnosis and treatment. MOCS therefore functions not merely as a supplementary tool but as a transformative bridge between traditional symptom-based assessments and culturally embedded behavioural observations.

Importantly, early correlational observations between MOCS, the Narcissistic Personality Pattern Test (NPPT), and the PGI Health Questionnaire N2 (N2) demonstrate an additional layer of clinical significance. Many clients presenting with narcissistic personality traits simultaneously exhibits compulsive reassurance-seeking, detail-oriented communication, hyper correctness, and cognitive rigidity patterns often overshadowed by prominent NPD features.

MOCS helps illuminate these underlying obsessive–compulsive tendencies that remain undetected in NPPT profiles alone. Likewise, N2 findings reflecting anxiety, guilt patterns, and internal stress responses complement MOCS scores, reinforcing a clearer picture of obsessive–compulsive underpinnings within narcissistic presentations. Together, these tools reveal that a subset of NPD clients exhibit pronounced OCD like behavioural patterns, which fundamentally alters case conceptualization and therapeutic direction.

With planned standardisation, factor analysis, inter-rater reliability testing, and robust psychometric validation, MOCS holds the potential to become India's first culturally grounded OCD behavioural scan. Its integration into clinical, counselling, and research settings can enhance diagnostic accuracy, support early intervention, and contribute to a more holistic understanding of obsessive–compulsive phenomena across diverse populations. Ultimately, MOCS aims to empower practitioners, enrich academic inquiry,

and improve client outcomes, thereby strengthening the broader mental health ecosystem in India especially in complex presentations where obsessive traits coexist with personality disorders such as NPD.

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