CME ACTIVITY

Sponsored by Physicians Postgraduate Press, Inc.

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education. To obtain credit, please read the following article and complete the posttest as instructed on page 352.

CME Objectives

After completing this CME activity, the psychiatrist should be able to:

- Recognize the patterns of remission and relapse of illness in patients with obsessive-compulsive disorder
- Assess the utilization of treatment options for OCD including SRIs and behavior therapy.
- Consider behavior therapy as a treatment option for patients with obsessive-compulsive disorder.

Statement of Need and Purpose

Physicians responding to articles in *The Journal of Clinical Psychiatry* and its related CME activities have indicated a need to better understand factors that affect the management of patients with obsessive-compulsive disorder. This CME enduring material presents current information to address that need. There are no prerequisites for participating in this CME activity.

Accreditation Statement

Physicians Postgraduate Press is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Credit Designation

Physicians Postgraduate Press designates this educational activity for a maximum of 1 hour in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Faculty Disclosure

In the spirit of full disclosure and in compliance with all Accreditation Council for Continuing Medical Education Essentials, Standards, and Guidelines, all faculty for this CME activity were asked to complete a full disclosure statement. The information received is as follows:

Drs. Eisen, Goodman, Keller, and Rasmussen, Mss. DeMarco and Warshaw, and Mr. Luce have no significant commercial relationships to disclose relative to the presentation.

Discussion of Investigational Information

During the course of their talks and discussions in this *Journal*, faculty may be presenting investigational information about pharmaceutical agents that is outside Food and Drug Administration–approved labeling. This information is intended solely as continuing medical education and is not intended to promote off-label use of any of these medications. Please refer to page 350 for a list of indications of off-label usage describing any medication discussed in this enduring material that, in the authors' clinical estimation, is outside the manufacturer's current recommendations for standard prescribing practices.

Patterns of Remission and Relapse in Obsessive-Compulsive Disorder: A 2-Year Prospective Study

Jane L. Eisen, M.D.; Wayne K. Goodman, M.D.; Martin B. Keller, M.D.; Meredith G. Warshaw, M.S.S., M.A.; Lynne M. DeMarco, M.S.P.H.; Douglas D. Luce; and Steven A. Rasmussen, M.D.

Objective: This study examined the course of illness in patients with obsessive-compulsive disorder (OCD) over a 2-year period.

Method: Sixty-six patients with a primary diagnosis of DSM-III-R OCD were followed prospectively for 2 years. Baseline information was collected on demographic characteristics, Axis I and II diagnoses, and severity of OCD symptoms. Follow-up measures obtained at 3, 6, 12, and 24 months after baseline assessment included information on symptomatic and diagnostic status as well as behavioral and somatic treatments received.

***Results*:** The probability of full remission from OCD over the 2-year period was 12%. The probability of partial remission was 47%. After achieving remission from OCD, the probability of relapse was 48%. No factors were identified that significantly predicted full or partial remission. Seventy-seven percent (N = 51) of the subjects received a serotonin reuptake inhibitor (SRI) for ≥ 12 weeks, and 68% (N = 45) received medium-to-high doses of SRIs for ≥ 12 weeks. Only 18% received a full trial of behavior therapy.

Conclusion: Despite exposure to at least 1 adequate trial of an SRI, the likelihood of full remission of OCD in this study was low. Results of this study also suggest that behavior therapy may be underutilized.

(J Clin Psychiatry 1999;60:346–351)

Received March 24, 1998; accepted Aug. 24, 1998. From the Department of Psychiatry and Human Behavior, Brown University, Providence, R.I. (Drs. Eisen, Keller, and Rasmussen, and Mss. Warshaw and DeMarco); the University of Florida at Gainesville (Dr. Goodman); and Brown University, Providence, R.I. (Mr. Luce).

Presented at the 148th annual meeting of the American Psychiatric Association, May 20–25, 1995, Miami Beach, Fla.

The authors thank Barbara Van Noppen, M.S.W., for assistance in data collection, and Claire Walker for data management.

Reprint requests to: Jane L. Eisen, M.D., Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906.

Demographic, epidemiologic, and clinical features of obsessive-compulsive disorder (OCD) have been well characterized.[1,2] However, little is known about the course of this disorder in terms of patterns of remission and relapse and the factors that influence these patterns.

Earlier retrospective follow-up studies of OCD have consistently shown that the course of this disorder is usually chronic; patients were rarely symptom-free at follow-up.[3–7] These studies suffered from a number of methodologic limitations: a lack of standardized criteria to determine diagnosis, diagnoses based on chart review, a lack of structured interviews, retrospective study design, and a lack of consensus on definitions of relapse, remission, and recovery. In keeping with older literature, a more recent retrospective study has shown that the course of OCD is usually one of waxing and waning.[1] That is, once a patient develops OCD, obsessions and/or compulsions are continuously present with varying degrees of intensity over time. Relatively few patients described either a progressively deteriorative course or a truly episodic course with complete absence of symptoms between episodes.[1] Although this study had some methodologic advantages over previous studies, it was not conducted prospectively. The effect of treatment on course of illness was not examined, and it was conducted prior to the widespread use of potent serotonin reuptake inhibitors (SRIs) for this disorder.

More optimistic findings about the course and prognosis of OCD have emerged from 2 more recent naturalistic follow-up studies. In a 1994 study conducted by Orloff et al.,[8] records of 85 patients with OCD followed for at least 1 year were evaluated. The majority of subjects were much improved at follow-up: the mean follow-up Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score was 10.1 ± 7.0 (in the range of mild-to-minimal obsessions and compulsions, which do not cause interference with functioning) compared with a baseline score of

23.7 ± 6.7. Ninety-nine percent of subjects had received at least a 10-week trial of an SRI, and 45% had received some behavior therapy using exposure/response prevention techniques. Of note is the finding that most patients were still taking medication at time of follow-up, with clear relapses in those patients who discontinued medication, suggesting that maintenance of improvement in obsessive-compulsive symptoms over time may require continued treatment.

In another recent study on course of illness in OCD, 54 children with OCD treated initially with clomipramine were reassessed 2 to 7 years after first referral.[9] Obsessive-compulsive symptoms were more severe in only 10 subjects (18.5%) at reassessment, with 73% considered much or very much improved. As a whole, the cohort had improved at follow-up. However, only 3 subjects (6%) were considered to be in true remission (defined as no obsessions or compulsions and no medication), and 23 subjects (43%) still met full criteria for OCD. The majority of patients were taking medication at follow-up. This study also suggests that appropriate somatic treatment may improve outcome only while the patient continues to receive treatment.

To our knowledge, no study has been undertaken which prospectively evaluates changes in obsessive-compulsive symptoms in adults using both measures of improvement as well as clearly defined definitions of remission and relapse. In this study, we analyze data gathered on rates of remission and relapse, treatment, and comorbidity of Axis I and II disorders in a cohort of 66 subjects with primary OCD who were assessed over a 2-year period. Our hypotheses were that (1) the majority of subjects would have a meaningful decrease in severity of illness with a corresponding improvement in ability to function and (2) the likelihood of either true remission or an episodic course (remission followed by relapse) would be rare.

METHOD

Subjects

After giving written informed consent, 77 subjects from 2 university-based OCD clinics participated in the study. Patients were referred from a number of sources, including inpatient, outpatient, private practice, mental health center, and self-referral. A consecutive sample of patients currently being seen at each clinic (either for evaluation or ongoing treatment) who met DSM-III-R criteria for OCD were asked to participate. The mean ± SD age of the participants was 33.5 ± 11.9 years; 42 subjects (55%) were female.

Inclusion criteria were the diagnosis of DSM-III-R OCD, age of 18 years or older, a willingness to be followed for 2 years, and an ability to understand and sign a consent form. Patients with other comorbid diagnoses were included but had to have a primary diagnosis of OCD. Primary diagnosis was defined as the dominant disorder for which treatment was sought.

Baseline Measures

Baseline demographic data included gender, age at onset of OCD, marital status, duration of illness, and educational level. Baseline measures included the following instruments: items combined from the Structured Clinical Interview for DSM-III-R Non-Affective Disorders, Patient Version (SCID-P)[10] and the Research Diagnostic Criteria Schedule for Affective Disorders and Schizophrenia-Lifetime version (SADS-L)[11] to make up the SCALUP, an instrument used in the Harvard/Brown Anxiety Disorders Research Program[12]; the Y-BOCS[13,14]; the Structured Interview for DSM-III Personality Disorders[15]; and the Global Assessment Scale (GAS).[16]

Follow-Up Measures

Follow-up measures were obtained at 3, 6, 12, and 24 months after baseline assessment. Baseline measures were repeated (excluding the Structured Interview for DSM-III Personality Disorders) at these interim assessments, in addition to the Longitudinal Interval Follow-Up Evaluation (LIFE), a semistructured instrument used to collect detailed information on symptomatic status, diagnostic status, and behavioral and somatic treatment received.[17,18] As part of the LIFE, Psychiatric Status Ratings for OCD (PSRs) were assessed. PSRs were originally developed for the National Institute of Mental Health (NIMH) Collaborative Depression Study[17]; PSRs were subsequently developed for OCD as well as other anxiety disorders.[18] PSRs are assigned at follow-up visits for each week since the previous visit, using a 6-point scale ranging from 6 (severely symptomatic and unable to function) to 0 (no obsessive-compulsive symptoms and no avoidance) (Appendix 1).

Course of OCD was assessed in 2 ways: (1) reduction in severity of OCD symptoms and (2) remission/relapse probability over time. Two definitions were used to define remission, both of which required a change in severity of symptoms and impact on functioning that were sustained over at least 8 consecutive weeks. The most rigorous definition of remission required a sustained PSR ≤ 2, indicating essentially no obsessions or compulsions (full remission). A less rigorous definition of remission re-

quired a decrease in obsessions and compulsions to less than 1 hour per day, with a corresponding PSR ≤ 4 (partial remission). The rates of probability of remission and relapse were calculated for those subjects whose initial Y-BOCS scores were ≥ 16. Patients were considered to have relapsed if they had a PSR ≥ 5 (Y-BOCS score ≥ 16) for at least 1 week after fulfilling criteria for remission.

Information on behavior therapy included amount of time spent in behavior therapy sessions, time spent doing homework, and whether the patient practiced exposure and response prevention and/or imaginal homework. Patients were considered to have received adequate behavior therapy if they reported participating in behavior therapy with a therapist who used exposure and response prevention and if they spent at least 20 hours during the course of treatment practicing exposure and response prevention homework assignments. Pharmacologic treatment data were gathered, including dose and duration of medications. Patients had to have received a minimum of 12 weeks of at least 1 SRI (clomipramine, fluoxetine, fluvoxamine, paroxetine, or sertraline) to be considered as having received adequate pharmacotherapy for OCD. Medium-to-high doses of SRIs were defined as the following doses: fluvoxamine, ≥ 150 mg/day; clomipramine, ≥ 150 mg/day; and fluoxetine, ≥ 40 mg/day.

Of the 77 subjects who initially agreed to enter the study, 66 patients (86%) completed the final interview at 24 months. Of the remaining 11 patients, 5 had completed only the baseline assessment, 4 subjects had completed through the 3-month interval, 1 subject had completed the 6- and 12-month assessments but was unavailable for the 3- or 24-month assessments, and 1 subject had completed all but the 24-month assessment. There were no statistically significant differences between completers and noncompleters on mean baseline Y-BOCS scores (21.2 ± 9.3 vs. 20.2 ± 8.8, respectively) or baseline GAS scores (55.6 ± 13.6 vs. 53.8 ± 10.2, respectively).

The interviews were conducted in person by experienced clinical interviewers. The interviewers received extensive training through the use of videotaped interviews to teach the administration of the instruments, as well as to establish interrater reliability. Following the initial training, the raters' interview techniques were monitored throughout the study by a study coordinator to maintain uniform assessment techniques, as well as to resolve diagnostic questions. The study coordinator had been previously involved in monitoring raters for the Harvard/Brown Anxiety Disorders Research Program, which used similar methodologies and instruments.[12]

Statistical Analysis

The 66 subjects who completed the 24-month assessment were included in the data analysis. Course and effect of predictors on probability of remission were analyzed using standard survival analysis methods. Kaplan-Meier life tables were constructed for time to remission and probabilities of remission.

RESULTS

Demographics and Clinical Features

Forty-two (55%) of the 77 subjects who entered the study were women. Thirty-one subjects (40%) were married, and 48% were currently employed. Mean ± SD age at baseline was 33.7 ± 11.8 years. Mean ± SD age at onset of OCD was 19.9 ± 5.0 years, and the mean ± SD duration of illness prior to study entry was 16.0 ± 11.5 years. Comorbid diagnoses and types of obsessions and compulsions at intake are listed in Table 1 and Table 2, respectively. Mean ± SD GAS score at intake was 55.3 ± 13.1. Mean ± SD baseline Y-BOCS score was 21.3 ± 9.3, with no significant differences in severity of OCD between sites. At the initial study visit, 60 (78%) of the 77 subjects had Y-BOCS scores ≥ 16 (in episode at baseline), 8 had scores of 8–15 (in partial remission at baseline), and 9 had scores < 8 (in full remission at baseline). Similarly, 52 (79%) of the 66 completers were in episode at baseline.

Course and Severity of Illness

Subjects who were not in partial or full remission at baseline had a 47% probability of achieving at least partial remission during the 2-year study period (Figure 1). However, there was only a 12% probability of achieving full remission. For subjects who achieved partial remission from OCD, the probability of subsequent relapse was 48% (Figure 2).

At the end of 2 years, 32 (48%) of the 66 completers still met full criteria for OCD (Y-BOCS score ≥ 16), 35% were in partial remission, and 17% were in full remission. Mean ± SD Y-BOCS scores at 12 and 24 months were 15.8 ± 8.8 and 15.4 ± 9.0, respectively. For those patients (N = 52) who began the study with Y-BOCS scores ≥ 16, mean Y-BOCS scores at 12 and 24 months were 17.7 ± 8.4 and 17.0 ± 9.0, respectively.

Of the 52 completers with Y-BOCS scores ≥ 16 at baseline, 5 patients (9%) had > 75% decrease in Y-BOCS scores over the 2 years studied, 12 patients (23%) had decreases in Y-BOCS scores between 50% and 75%, 11 patients (21%) had decreases in Y-BOCS scores between 25% and 49%, and 19 patients (37%) had decreases in

Table 1. Comorbidity in Patients With Primary Obsessive-Compulsive Disorder (OCD) at Intake (N = 77)

	Lifetime		Current	
Comorbid Diagnosis	N	%	N	%
Axis I				
Major depression	42	54.6	12	15.6
Social phobia	18	23.4	14	18.2
Simple phobia	16	20.8	12	15.6
Generalized anxiety disorder	15	19.5	11	14.3
Panic disorder	9	11.7	4	5.2
Posttraumatic stress disorder	6	7.8	5	6.5
Anorexia nervosa	6	7.8	1	1.3
Body dysmorphic disorder	2	2.6	1	1.3
Chronic motor/vocal tics	5	6.5	1	1.3
Tourette's syndrome	4	5.2	4	5.2
Trichotillomania	2	2.6	1	1.3
Axis II				
Avoidant personality disorder	19	24.7	19	24.7
Borderline personality disorder	2	2.6	2	2.6
Dependent personality disorder	11	14.3	11	14.3
Obsessive-compulsive personality disorder	20	26.0	20	26.0
Paranoid personality disorder	4	5.2	4	5.2

Table 2. Principal Obsessions and Compulsions at Intake (N = 77)

Feature	N	%
Obsession		
Aggressive	43	55.8
Contamination	35	45.5
Symmetry	25	32.5
Fear of saying the wrong thing	16	20.8
Sexual	8	10.4
Hoarding	8	10.4
Religious	8	10.4
Somatic	8	10.4
Need to know	5	6.5
Compulsion		
Washing	38	49.4
Checking	32	41.6
Ordering	21	27.3
Repeating	12	16.1
Counting	12	15.6
Hoarding	12	15.6
Confessing	11	14.3
Touching	5	6.5
Religious	3	3.9

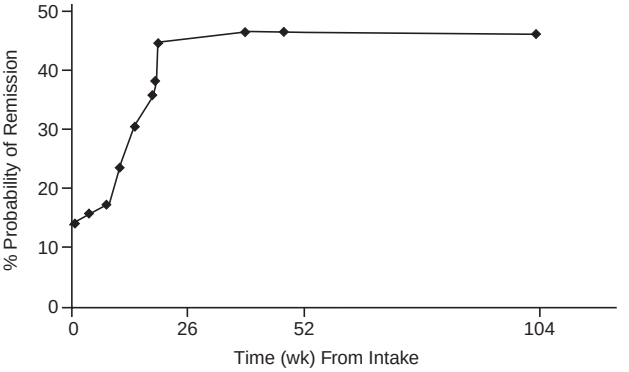
Y-BOCS scores of less than 25%. Five patients (10%) had worsening of their obsessive-compulsive symptoms, with Y-BOCS score increases.

Treatment

Fifty-one completers (77%) received an SRI for ≥ 12 weeks. Forty-five subjects (68%) of the 66 completers received ≥ 12 weeks of at least 1 SRI at medium-to-high doses, and 7 subjects (11%) received 2 or more medium-to-high–dose SRI trials for at least 12 weeks during the 24-month period they were followed. Including patients with more than 1 trial, 17 subjects (26%) received ≥ 150 mg/day of fluvoxamine, 27 subjects (41%) received ≥ 150 mg/day of clomipramine, and 8 subjects (12%) received ≥ 40 mg/day of fluoxetine. Mean ± SD durations on treatment with specific SRIs were as follows: fluvoxamine, 63.2 ± 43.1 weeks; clomipramine, 66.3 ± 35.0 weeks; and fluoxetine, 36.7 ± 30.9 weeks.

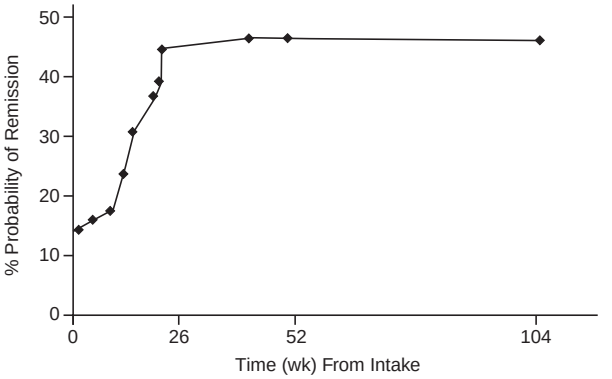
Ten subjects (15%) received an SRI ≥ 12 weeks and an adequate trial of behavior therapy, 46 subjects (70%) received an SRI ≥ 12 weeks but inadequate or no behavior therapy, 2 patients (3%) received adequate behavior therapy alone, and 8 subjects (12%) received neither a medication trial ≥ 12 weeks nor behavior therapy.

Figure 1. Probability of Partial Remission Over 2 Years[a]



[a]For subjects who achieved either partial remission or full remission from OCD. Partial remission = PSR score ≤ 4 for 8 weeks.

Figure 2. Probability of Relapse After Remission[a]



[a]Relapse = PSR score ≥ 5 for at least 1 week following remission.

Predictors of Outcome

No significant effect on course of illness (as defined by effect on probability of remission) was found for a number of variables, including avoidant and dependent personality disorders, major depressive disorder, intermittent depressive disorder, tic disorders, or onset of OCD before age 14. There was a trend for those subjects with an improvement in severity of obsessive-compulsive symptoms at 3 months (≥ 25% decrease in Y-BOCS score) to be more likely to achieve remission during the course of the 2-year study (Wilcoxon $\chi^2 = 3.3$, df = 1, p = .068).

DISCUSSION

We studied course of illness in 66 patients with a primary diagnosis of OCD over 2 years using a prospective, naturalistic design. Comorbidity and symptom subtypes were similar to the cohort described in the OCD field trial conducted in 1995.[19] We found a 47% probability of achieving at least partial remission and a 12% probability of achieving complete remission over a 2-year period. For subjects who achieved remission from OCD, the probability of subsequent relapse was 48%.

In terms of improvement, 54% of the subjects had a ≥ 25% decrease in baseline Y-BOCS scores over the course of 2 years. Our findings are not as optimistic about the course of illness in OCD compared with those of Orloff et al.,[8] who reported that 87% of their patients had a ≥ 25% decrease in Y-BOCS score at follow-up. The disparity may be due to differing methodologies used (e.g., prospective vs. cross-sectional, direct patient interview vs. chart review). However, these results support the findings of most previous studies, i.e., that, even with adequate pharmacotherapy, course of illness in OCD is usually continuous, with fluctuations in severity, and that only 10% to 12% of patients achieve true remission of symptoms.

Over two thirds of the patients in this study received at least 12 weeks of medium-to-high doses of an SRI. Even with adequate pharmacotherapy, those subjects who experienced complete remission of obsessive-compulsive symptoms were in the minority. This finding, in keeping with most of the retrospective and prospective studies of OCD, supports the notion that the majority of people who meet full criteria for OCD continue to suffer from obsessions and compulsions even though they may experience considerable improvement in both the intensity of their symptoms and the corresponding degree of impairment.

Patients were undertreated with behavior therapy; only 12 patients (18%) received the recommended type and duration of behavior therapy. We are unable to determine whether underutilization of this modality was caused by lack of exposure to behavior therapy or whether it was because patients, when given the opportunity, were not fully compliant. Further work needs to be done to understand the lack of adequate behavior therapy and to address reasons that an adequate trial of a treatment for OCD with demonstrated efficacy has not been conducted.

There are several limitations to this study. The number of patients enrolled was small, and therefore the lack of identifiable predictors to course of illness should be interpreted cautiously. In addition, we assessed baseline presence of Axis I and II disorders, but did not follow these disorders prospectively. Whether ongoing comorbid symptomatology affects the course of OCD cannot be determined by this study. Furthermore, because the mean duration of illness prior to study entry was long (16.0 years), the course of recent-onset OCD also was not addressed in this study. Further work needs to be done prospectively using a large number of subjects to adequately determine factors that contribute to either chronic course despite state-of-the-art treatment or, conversely, remission without relapse.

Drug names: clomipramine (Anafranil), fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), sertraline (Zoloft).

Disclosure of off-label usage: The authors of this article have determined that, to the best of their clinical estimation, no investigational information about pharmaceutical agents has been presented herein that is outside Food and Drug Administration–approved labeling.

REFERENCES

1. Rasmussen SA, Eisen JL. The epidemiology and clinical features of OCD. In: Jenike MA, ed. Psychiatric Clinics of North America, vol 15, no. 4. Philadelphia, Pa: WB Saunders Co; 1992:743–758
2. Rasmussen SA, Tsuang MT. DSM-III obsessive-compulsive disorder: clinical characteristics and family history. Am J Psychiatry 1986;143: 317–322
3. Pollitt J. Natural history of obsessional states: a study of 150 cases. BMJ 1957;1:194–198
4. Ingram IM. Obsessional illness in mental hospital patients. J Ment Sci 1961;107:382–402
5. Kringlen E. Obsessional neurotics: a long-term follow-up. Br J Psychiatry 1965;111:709–722
6. Lo WH. A follow-up study of obsessional neurotics in Hong Kong Chinese. Br J Psychiatry 1967;113:823–832
7. Goodwin DW, Guze SB, Robins E. Follow-up studies in obsessional neurosis. Arch Gen Psychiatry 1969;20:182–187
8. Orloff LM, Battle MA, Baer L, et al. Long-term follow-up of 85 patients with obsessive-compulsive disorder. Am J Psychiatry 1994;151:441–442
9. Leonard HL, Swedo SE, Lenane MC, et al. A two to seven year follow-up study of 54 obsessive-compulsive children and adolescents. Arch Gen Psychiatry 1993;50:429–439
10. Spitzer RL, Williams JBW, Gibbon M, et al. Structured Clinical Interview for DSM-III-R, Patient Version (SCID-P). New York, NY: Biometric Re-

search, New York State Psychiatric Institute; 1988
11. Endicott J, Spitzer RL. A diagnostic interview: the Schedule for Affective Disorders and Schizophrenia (SADS-L). Arch Gen Psychiatry 1978;35: 837–844
12. Keller MB, Lavori PW, Nielsen E. SCALUP (SCID-P + SADS-L Upjohn). Available from Martin B. Keller, Brown University Department of Psychiatry and Human Behavior, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906
13. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS), I: development, use, and reliability. Arch Gen Psychiatry 1989;46:1006–1011
14. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS), II: validity. Arch Gen Psychiatry 1989; 46:1012–1016
15. Stangl D, Pfohl B, Zimmerman M, et al. A structured interview for the DSM-III personality disorders: a preliminary report. Arch Gen Psychiatry 1985;42:591–596
16. Endicott J, Spitzer RL, Fleiss JL, et al. The Global Assessment Scale: a procedure for measuring overall severity of psychiatric disturbance. Arch Gen Psychiatry 1976;33:766–771
17. Keller MB, Lavori PW, Friedman B, et al. The Longitudinal Interval Follow-up Evaluation: a comprehensive method for assessing outcome in prospective longitudinal studies. Arch Gen Psychiatry 1987;44:540–548
18. Warshaw MG, Keller MB, Stout RL. Reliability and validity of the Longitudinal Interval Follow-up Evaluation for assessing outcome of anxiety disorders. J Psychiatr Res 1994;28:531–545
19. Foa EB, Kozak MJ, Goodman WK, et al. DSM-IV field trial: obsessive-compulsive disorder. Am J Psychiatry 1995;152:90–96

Appendix 1. Psychiatric Status Rating Scale (PSR) for Obsessive-Compulsive Disorder (OCD)

Severity of Symptoms	Rating	Description
In episode		
Severe	6	Obsessions or compulsions consume most waking hours. Experiences severe-to-extreme anxiety. Social and occupational functioning profoundly impaired. Y-BOCS score = 26–40
Marked	5	Obsessions or compulsions are present at least 1 hour daily. Experiences moderate-to-severe anxiety. Significant social or occupational impairment. Y-BOCS score = 16–25
Partial remission		
Moderate	4	Obsessions or compulsions occur most hours of the day but less than an hour/day. Experiences mild-to-moderate anxiety. Some interference with social or occupational functioning. Y-BOCS score = 12–15
Mild	3	Most hours of the day are free of symptoms; however, obsessions or compulsions occur regularly. Experiences mild anxiety. Mild interference with social or occupational functioning, but overall performance not impaired. Y-BOCS score = 8–11
Full remission		
Minimal	2	Most hours of the day are free of symptoms, although obsessions or compulsions occur occasionally. Experiences minimal anxiety. Normal lifestyle. Y-BOCS score = 4–7
None	1	Obsessions or compulsions occur rarely and are in the range of normal functioning. Y-BOCS score = 0–3

Instructions

Psychiatrists may receive 1 hour of Category 1 credit toward the American Medical Association Physician's Recognition Award by reading the article starting on page 346 and correctly answering at least 70% of the questions in the posttest that follows.

1. Read each question carefully and circle the correct corresponding answer on the Registration form.
2. Type or print your full name, address, Social Security, phone, and fax numbers in the spaces provided.
3. Mail the Registration form along with a check, money order, or credit card payment in the amount of $10 to: Physicians Postgraduate Press, Office of CME, P.O. Box 752870, Memphis, TN 38175-2870.
4. For credit to be received, answers must be postmarked by the deadline shown on the CME Registration form. After that date, correct answers to the posttest will be printed in the next issue of the *Journal*.

All replies and results are confidential. Answer sheets, once graded, will not be returned. Unanswered questions will be considered incorrect and so scored. Your exact score can be ascertained by comparing your answers with the correct answers to the posttest, which will be printed in the *Journal* issue after the submission deadline. The Physicians Postgraduate Press Office of Continuing Medical Education will keep only a record of participation, which indicates the completion of the activity and the designated number of Category 1 credit hours that have been awarded.

1. Which of the following statements is true about the course of obsessive-compulsive disorder (OCD) based on this 2-year prospective study of adults with primary OCD?

a. Almost all patients (80%) achieved full remission from OCD.
b. The majority of patients (60%) achieved full remission from OCD.
c. Almost all patients (80%) achieved at least partial remission from OCD, i.e., obsessions and compulsions occupied less than an hour daily, patients experienced mild-to-moderate anxiety, and mild-to-some interference with functioning.
d. The majority of patients (60%) achieved at least partial remission from OCD.
e. About half the patients achieved at least partial remission from OCD.

2. What is the likelihood that patients with OCD will relapse, i.e., meet full criteria for OCD, after remitting from OCD?

a. Almost all patients (80%) will relapse following partial or complete remission from OCD.
b. The majority of patients (60%) will relapse following partial or complete remission from OCD.
c. There is nearly a 50% chance of relapse once patients achieve partial or complete remission from OCD.
d. The majority of patients (60%) will continue to be remitted from OCD once they achieve partial or complete remission.
e. Almost all patients (80%) stay well (in remission) once they achieve partial or complete remission from OCD.

3. What is the mean age at onset of OCD?

a. 25 years
b. 20 years
c. 17 years
d. 12 years
e. None of the above

4. For this study, what percentage of patients still met full criteria for OCD at the end of 2 years?

a. More than 75%
b. More than 50%
c. 50%
d. More than 25%
e. Less than 25%

5. In what percentage of patients in this study was the course of OCD deteriorative, i.e., OCD symptoms became more severe over time?

a. Patients rarely experienced progressive worsening of their OCD symptoms (10%).
b. Half the patients experienced worsening of their OCD symptoms over time.
c. About 25% of patients experienced progressive worsening of their OCD.
d. The majority of patients (60%) experienced progressive worsening of their OCD.
e. Almost all patients (80%) experienced progressive worsening of their OCD.

6. In this study, approximately how many patients received medium-to-high–dose SRIs for at least 12 weeks?

a. 90%
b. 70%
c. 50%
d. 30%
e. 10%

7. Based on this naturalistic study, which statement best describes the treatment patients receive for OCD?

a. Almost all patients (80%) receive at least 12 weeks of an SRI and adequate behavioral therapy.
b. The majority of the patients (60%) receive at least 12 weeks of an SRI and adequate behavioral therapy.
c. Most patients (70%) receive at least 12 weeks of an SRI but inadequate behavioral therapy.
d. About half the patients receive at least 12 weeks of an SRI but inadequate behavioral therapy.
e. Most patients (70%) do not receive either 12 weeks of an SRI or adequate behavioral therapy.

8. Based on this naturalistic study of patients with OCD over a 2-year time period, what percentage of patients received both a standard trial of an SRI and an adequate trial of behavioral therapy?

a. 90%
b. 70%
c. 50%
d. 30%
e. 15%

Answers to the November 1998 CME posttest

1. d 2. b 3. e 4. a 5. d 6. e 7. b 8. a

Circle the one correct answer for each question.

1.	a	b	c	d	e
2.	a	b	c	d	e
3.	a	b	c	d	e
4.	a	b	c	d	e
5.	a	b	c	d	e
6.	a	b	c	d	e
7.	a	b	c	d	e
8.	a	b	c	d	e

Print or type

Name _____

Social Security number _____ – _____ – _____
(for CME credit recording purposes)

Degree _____ Specialty _____

Affiliation _____

Address _____

City, State, Zip _____

Phone ( ) _____

Fax ( ) _____

E-mail _____

Hospital: ❑ Private Practice: ❑ Resident: ❑ Intern: ❑

Deadline for mailing

For credit to be received, the envelope must be postmarked no later than October 31, 1999.

Keeping a copy for your files

Retain a copy of your answers and compare them with the correct answers, which will be published after the submission deadline.

Payment

A $10 payment must accompany this form. You may pay by check, money order, or credit card (Visa or MasterCard). Make check or money order payable to Physicians Postgraduate Press. If paying by credit card, please provide the information below.

Check one: ❑ Visa ❑ MasterCard

Card number _____

Expiration date _____

Your signature _____

Please evaluate the effectiveness of this CME activity by answering the following questions.

1. Was the educational content relevant to the stated educational objectives? ❑ Yes ❑ No
2. Did this activity provide information that is useful in your clinical practice? ❑ Yes ❑ No
3. Was the format of this activity appropriate for the content being presented? ❑ Yes ❑ No
4. Did the method of presentation hold your interest and make the material easy to understand? ❑ Yes ❑ No
5. Achievement of educational objectives:
   A. Enabled me to recognize the patterns of remission and relapse of illness in patients with obsessive-compulsive disorder. ❑ Yes ❑ No
   B. Enabled me to assess the utilization of treatment options for OCD including SRIs and behavior therapy. ❑ Yes ❑ No
   C. Enabled me to consider behavior therapy as a treatment option for patients with obsessive-compulsive disorder. ❑ Yes ❑ No
6. Did this CME activity provide a balanced, scientifically rigorous presentation of therapeutic options related to the topic, without commercial bias? ❑ Yes ❑ No
7. Does the information you received from this CME activity confirm the way you presently manage your patients? ❑ Yes ❑ No
8. Does the information you received from this CME activity change the way you will manage your patients in the future? ❑ Yes ❑ No
9. Please offer comments and/or suggested topics for future CME activities.

   _____

   _____

   _____

   _____
10. How much time did you spend completing this CME activity?

    _____

TEAR OUT AND MAIL THIS PAGE, ALONG WITH YOUR PAYMENT, TO:
PHYSICIANS POSTGRADUATE PRESS • OFFICE OF CONTINUING MEDICAL EDUCATION • P.O. BOX 752870 • MEMPHIS, TN 38175-2870

IF YOU ARE PAYING BY CREDIT CARD, YOU MAY FAX THIS PAGE TO:
OFFICE OF CONTINUING MEDICAL EDUCATION AT 901-751-3444