

2001 Research Award Winners Announced

On March 19, 2001, Michael A. Jenike, MD, director of the OCD Institute in Belmont, Massachusetts and chair of the Obsessive Compulsive Foundation's Scientific Advisory Board, and Janet Emmerman, president of the OC Foundation board of directors, announced the winners of the Foundation's 2001 Research Awards. "These Awards are given annually," said Emmerman, "to researchers whose proposals promise to advance our knowledge of the causes of Obsessive Compulsive Disorder and provide effective treatments for it."



Thomas Joiner, Ph.D.

In making the announcement, Jenike, who is also a professor at Harvard Medical School, praised the projects as being critical to the study, understanding and treatment of OCD.

The 2001 OCF Research

Awards winners are: Maria C. Rosario-Campos, MD, a post-doctoral fellow at the Child Study Center at Yale Medical School in New Haven, Connecticut, for "A Family Genetic Study of Children and Adolescents with Obsessive Compulsive Disorder;" Cary R. Savage, Ph.D., assistant professor, Department of Psychiatry, Massachusetts General Hospital, in Charlestown, MA, for "Developing a Cognitive Rehabilitation Program for OCD;" and Thomas Joiner, Ph.D., professor, Department of Psychology, Florida State University, Tallahassee, Florida, for "Relation of the Serotonin Transporter Gene to OCD."

Lee Baer, Ph.D., author of several seminal books on cognitive behavior therapy and its relevance to OCD as well as the recently published "Imp of the Mind," chaired the Scientific Advisory Board subcommittee that reviewed the 17 proposals that

were submitted. In evaluating the proposals this year, Baer stated, we looked for two main factors: the importance of the study to the understanding or treatment of OCD and the scientific rigor of the application.



Carey R. Savage, Ph.D.

"A Family Genetics Study of Children and Adolescents with OCD" – Maria Rosario-Campos, MD

Rosario-Campos, who received her medical degree from the Bahiana Medical School in Bahia, Brazil in 1990, did a residency in Psychiatry at Santa Casa Medical School and an additional residency in Child Psychiatry at GEPI in Sao Paul, Brazil. Her thesis for her Master's degree in Psychiatry was entitled "Early-Onset v. Late-Onset OCD." Rosario-Campos, who was assistant professor at Santa Casa Medical Hospital from 1996-99, has published extensively on both OCD and Tourette's Syndrome.

In recommending funding for Rosario-Campos' study, Baer observed that it would provide important information about the genetic transmission of OCD and related disorders by carefully studying the family members of children and adolescents with OCD.

While working on this study, Rosario-Campos will be supervised by David



Maria C. Rosario-Campos, MD

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From the Foundation

Dear Friends,

I'm writing this surrounded by what feels like clothes lines hung with pillow-sized sheets of paper, covered not with designs by Ralph Lauren, but red, black and blue squiggles. We're in the midst of "designing" the 8th Annual OCF Conference. The illegible slashes and mark-outs are my post-Luvox penmanship.

We're in Phase IV. We met and planned in November, solicited proposals in December and reviewed and debated in February. Now we're putting the actual program together. We have a fragile framework – Friday, Saturday and Sunday; the rest is chaos. Maybe I should cut back on the SSRIs long enough to get some rectilinear order here.



In response to our Call for Proposals, we received an avalanche of presentations. Some actually on our preprinted proposal form as we requested. Many were not. Based on the way I've been drawing and redrawing the hour grids for the presentations, I know I'm going to have to attend "Oops! My Slip Is Showing: Insight into Relapses" on Friday afternoon. It's a workshop on relapse prevention by Drs.

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Bulletin Board

GREATER BOSTON AFFILIATE

The Greater Boston Affiliate of the OCF is in the process of revising an informational packet the organization distributes to HELPLINE callers. If you have any information regarding OCD Help/Support/Treatment groups or OCD treatment providers in Massachusetts, please call Judie Beshwaty at 617.855.3371.

The Greater Boston Affiliate is also starting a newsletter and is looking for local printing or desktop publishing companies to donate their services to this effort. If you are interested in being involved or donating your services, call Denise Egan at 617.855.2252.

NATIONAL ANXIETY DISORDERS SCREENING DAY

May 2 is National Anxiety Disorders Screening Day. This event is sponsored by the National Mental Health Association. The goal of this screening day is to educate people about anxiety disorders, including OCD; help people with anxiety disorders find appropriate treatment; and destigmatize mental illness. For information about screening locations in your area, consult your state Mental Health Association, or call (888) 442-2022.

CBT FOR OCD AT HARVARD

Harvard Medical School is presently doing a study involving CBT and OCD. In conjunction with Massachusetts General Hospital, researchers and clinicians from Harvard Medical School are seeking participants with Obsessive Compulsive Disorder to take part in an ongoing research study. The purpose of the study is to examine the effectiveness of cognitive therapy for OCD. Participants will receive: A free clinical evaluation and 18 to 22 cognitive therapy sessions.

Who is eligible to participate? If you are between 18 and 65 years of age and suffer from OCD, you might be eligible for this study. You must be able to attend weekly sessions in Boston.

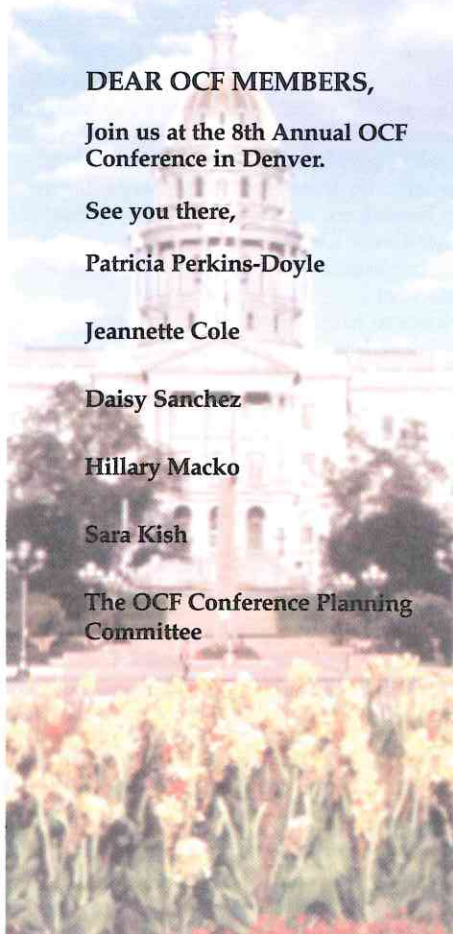
Benefits to participants: You may not receive any direct benefits from participating. However, it is possible that your OCD symptoms may improve from the cognitive therapy you'll receive. At this point,

there is some evidence that cognitive therapy may help individuals suffering from OCD. However, clinical testing is still experimental at this time.

Contact Information: This study is being conducted by Sabine Wilhelm, Ph.D., and Gail Steketee, Ph.D. If you would like further information, please contact Ulrike Buhlmann at the OCD Clinic/Harvard Medical School at (617) 724-4354 or send an email to bulhmann@wjh.harvard.edu. This study has received IRB Approval.

PARENTS AND CHILDREN WITH OCD

A network news magazine program known for its breakthrough reporting on OCD is producing a story about OCD in families. We are looking for very articulate parents with OCD who have a child or children, between the ages 10-15, who are also struggling with OCD. The OCD symptoms must still be very pronounced. If you are interested in sharing your story on our program, please email a brief description of your family to: Nancy.Gamerman@abc.com. Be sure to include day and evening phone numbers. You may also call: 1-800-221-7386, ext. 6785. Please respond as soon as possible.



DEAR OCF MEMBERS,

Join us at the 8th Annual OCF Conference in Denver.

See you there,

Patricia Perkins-Doyle

Jeannette Cole

Daisy Sanchez

Hillary Macko

Sara Kish

The OCF Conference Planning Committee

MARIST CONFERENCE

The 6th Annual Hudson Valley OCD Conference will be held on June 12, 2001, at Marist College in Poughkeepsie, NY from 1:30 PM to 9 PM. Originally the conference was scheduled for May 31, 2001, but the date had to be changed to June 12th. Please note this change.

The first evening speaker, Darin Dougherty, M.D., will address The Frontiers of Neurobiological Research by Way of Neuroimaging. The other evening speaker, Fred Penzel, Ph.D., will present What To Do When You Have A Loved One In Or Out Of Treatment.

For more information visit www.academic.marist.edu/ocd, email chris.vertullo@marist.edu or call (845) 473-2500, ext. 319.

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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Scientific Advisory Board

The Obsessive-Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 10,000 members worldwide. Its mission is to increase research, treatment and understanding of obsessive-compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to registered treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore and other programs.

DISCLAIMER: OCF does not endorse any of the medications, treatments, or products reported in this newsletter. This information is intended only to keep you informed. We strongly advise that you check any medications or treatments mentioned with your physician.

IDEA: A PRIMER FOR PARENTS

by Edward N. Matisik, J.D.

Congress passed the Education for All Handicapped Children Act in 1975 which, through a series of five amendments during the past 26 years, has become known as the Individuals with Disabilities Education Act (IDEA). IDEA helps parents and guardians obtain the educational services necessary to maximize their children's education in the public schools. It must be noted that IDEA applies only to students enrolled in the public schools—it does not apply to students in private schools, secular or religious. OCD has been recognized as a disability covered by IDEA.

IDEA has several basic provisions to assist parents in dealing with the public schools:

Free Appropriate Public Education

IDEA guarantees to each eligible child with a disability a "free appropriate public education" (FAPE). IDEA defines a "free appropriate public education" as special education and related educational services that: (1) are provided at public expense, under public supervision, and without charge to the student with a disability and his or her parents/guardians, (2) meet the standards of the agency supervising public education in the state in which the student with a disability attends school, (3) include an appropriate education from preschool through high school, and (4) conform with an "individualized education program" (IEP) as outlined in the section below. It may be helpful to look at how IDEA defines the first three words in "free appropriate public education" to better understand what constitutes a FAPE.

"Free"

All educational services—including special education services—must be provided free to the student and his or her parents. However, this does not include any incidental fees that would normally be charged to students without disabilities, or their parents, that are part of the regular educational program.

"Appropriate"

The educational services provided to a student with a disability must be tailored to that student and respond to the student's needs to advance both educationally and vocationally. This provision also requires the school to work with the parents in developing an Individualized Education Program (IEP) to specify the appropriate education for each student. IEPs are covered in more detail below.

"Public"

The provisions of IDEA only apply to students enrolled in the public schools. They do not apply to students enrolled in private religious or non-religious schools. Students with disabilities enrolled in private schools usually have the right to obtain only the educational services which

the private school chooses to provide.

Appropriate Evaluation

IDEA requires that all covered students with disabilities receive an "appropriate evaluation" for purposes of eligibility determination, suitability of educational services provided to the student, and evaluation of the student's performance in the services provided. Evaluation procedures must not be racially or culturally discriminatory, nor may they subject the student to unnecessary tests and assessments. Evaluation procedures must include obtaining the information necessary to enable the student to participate and progress in the school's general curriculum and appropriate activities. IDEA also requires that evaluators be trained in the administration and use of the tests they administer, and that a variety of test instruments and procedures be used to gather relevant information about the student. All information obtained from these assessments must be relevant to determining the education needs of the student.

FOR MORE INFORMATION ON OCD IN THE CLASSROOM and how to handle it, consider ordering "How to Recognize and Respond to OCD in School-Age Children." This is a two-tape video set produced by the OCD Foundation with the assistance of the Boston Affiliate, Jonathan Grayson, Ph.D. and Tamar Chansky, Ph.D.

One tape features a panel of students speaking about their school experiences and OCD. The second tape is a dramatization of situations that often arise in the classroom because a student has OCD.

Included in the set is "Teacher's Guidelines for Helping Children with Obsessive-Compulsive Disorder in the Classroom," which was written by Drs. Chansky and Grayson.

Call Daisy at (203) 315-2190 ext. 13 to order.

Individualized Education Program (IEP)

IDEA requires the public school to develop, in conjunction with the student's parents, an Individualized Education Plan. The IEP must be in writing and revised on a regular basis, usually yearly, as the student progresses. It may also be revised if an unexpected event happens to the student which affects his or her ability to learn or the nature of the disability. The IEP is developed by a committee of the following individuals: the parents of the child, at least one regular education teacher of the student (if any), at least one special education teacher of the student (if any), a representative of the local educational administrative agency who is familiar with the needs of students with disabilities and the

requirements of the law, a person who can interpret the instructional implications of testing results (which may be one of the previously named persons), other individuals who have special expertise or knowledge regarding the student (at the discretion of the parents and/or the committee), and the student with a disability when appropriate.

The IEP developed by this committee is required by law to include the following eleven components: (1) an assessment of the student's present educational performance, (2) an evaluation of how the student's disability presently affects his or her ability to participate in the general curriculum, (3) measurable annual and short-term goals, (4) the instruction, related services, and supplementary aids and services to be provided to the student, (5) the program modifications and supports that will be provided to school personnel to assist in delivering the specified services, (6) an explanation of the extent, if any, to which the student will not participate in regular classroom and extracurricular activities with nondisabled students, (7) the extent to which state- and school-administered general assessment tests will be modified for the student and/or how the student will be alternatively assessed, (8) the projected schedule for the services and modifications specified, (9) an assessment of the needs of the student for transition to the working world or higher education beginning at age 14 and updated annually thereafter, (10) notification to the student of his or her rights upon reaching the age of majority in his or her state of residence at least one year before reaching that age, and (11) how the student's progress will be measured and how his or her parents will be informed of the student's progress.

The public school is legally required by IDEA to follow the IEP and the parents of the student may pursue administrative remedies, lawsuits, or other measures if it fails to do so.

Least Restrictive Environment

IDEA requires that the public schools provide the FAPE in the "least restrictive environment" possible. This requirement is based on the law's presumption that "children with disabilities are most appropriately educated with their nondisabled peers and that special classes, separate schooling, or other removal of children with disabilities from the educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

The appropriate "least restrictive environment" for the student is determined by the student's IEP committee. However, as required by IDEA, the committee must start with the presumption that the student with disabilities should be educated

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OCD – OCPD Interface

by *Glen O. Gabbard, M.D.*
Callaway Distinguished Professor
The Menninger Clinic



Glen O. Gabbard, M.D.

Obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder (OCPD) are two distinct psychiatric entities that are frequently confused. This confusion is not limited to those outside the mental health professions. Even psychiatrists and other mental health profes-

sionals commonly use the two terms almost interchangeably. Distinguishing the two disorders is not simply ivory tower hair-splitting. OCD and OCPD require substantially different treatment approaches. Behavior therapy and medication (usually serotonin reuptake inhibitors) are the treatments of choice for OCD. Psychodynamic therapy will not improve the rituals and obsessional thoughts that are the hallmarks of that disorder. However, there is no evidence that any medication or behavior therapy is effective for OCPD. Clinical wisdom and some preliminary data suggest that psychodynamic therapy is much more useful. The exact interface between the two syndromes remains somewhat controversial, and I will summarize the current state of knowledge relevant to that interface.

HISTORY

Early psychoanalytic writing, such as Freud's classic case of the "Rat Man," conceptualized OCD as a neurotic disorder related to conflicts between the developing child and its mother. Disturbances around toilet training, during what Freud referred to as the "anal phase" of development, were thought to be particularly relevant. Subsequent analysts thought that while some patients had neurotic symptoms, such as rituals and obsessional thoughts, others manifested the conflicts as more pervasive personality patterns. Hence a distinction was made between obsessional neurosis, what we now call OCD, and obsessional character, or OCPD. The latter was labelled "anal character" by the analyst Karl Abraham, reflecting his view that anal conflicts were relevant to obsessional character in the same way that they applied to obsessional neurosis. He identified a triad of three personality traits as the hallmark of the condition: obstinacy, miserliness, and orderliness.

With increasing diagnostic refinement, the two disorders were often differentiated by the fact that OCD is mainly characterized by an "ego-dystonic" (that is, distress-inducing) need to perform rituals and think certain thoughts while OCPD is characterized by "ego-syntonic" per-

sonality traits. The designation "ego syntonic" referred to the observation that these traits generally do NOT cause distress to the individual. Family members and co-workers, however, may find them quite annoying. This distinction between ego-dystonic and ego-syntonic is not ironclad, though, since some persons with OCD become habituated to their symptoms and do not have as much distress over time while some persons with OCPD actually experience considerable distress from their drivenness and perfectionism. Highly sophisticated neuroscientific investigations of OCD eventually documented specific brain changes associated with OCD. These include significantly less total white matter, greater total cortex volume, and impaired myelination (Jenike et al, 1996), to name a few. These discoveries altered the understanding of the causes and mechanisms of the disorder so that neurotic conflict was thought to play much less of a role than originally conceived. Indeed, the retention of the adjectives "obsessive" and "compulsive" to denote both the Axis I disorder and the personality disorder on Axis II may be an unfortunate choice. Although OCPD is less studied, we have no data to suggest similar brain abnormalities in that condition.

RESEARCH ON OVERLAP BETWEEN OCD AND OCPD

The growing literature suggesting that OCD and OCPD are distinct from one another raises questions about how commonly they co-exist in the same person. Of course, the mere co-existence of the two conditions does not necessarily imply that they are related in terms of cause or similar biopsychosocial underpinnings. Most OCD research suggest a high frequency of personality disorders in general in OCD patients, probably in the range of 52-83%. Whether the presence of OCD increases one's likelihood of having OCPD, or vice-versa, is not entirely clear.

Baer and colleagues evaluated 96 patients with OCD for personality disorders and found that only 6% met the criteria for OCPD. On the other hand, Bejerot and his co-investigators investigated 36 patients with OCD and diagnosed 36% of them with OCPD. In most of these studies, other personality disorders are even more common than OCPD, arguing against a specific relationship between OCD and OCPD. For example, Rodrigues-Torres and Del Porto evaluated 40 OCD patients and 40 controls who did not have a psychiatric diagnosis. At least one personality disorder was found in 70% of the OCD patients while only 6 of the non-patient control group had any personality disorder at all. The most common personality disorder in the OCD patients was avoidant, which was present in 52.5% of the patients. In descending order, the frequency of other personality disorders was dependent (40%), histrionic (20%), paranoid (20%), and obsessive-compulsive (only 17.5%). The investigators also noted

considerable diagnostic overlap. In fact, 57.5% of the OCD group had two or more personality disorders. A novel approach to looking at the degree of overlap by Diaferia and colleagues measured the frequency of OCPD in other Axis I conditions and compared it to the prevalence of OCPD in patients with OCD. Of 277 patients in the study, 88 had OCD, 58 had major depressive disorder and 131 had panic disorder. OCPD was significantly more common in OCD patients than in those with panic and depression. They also noted that OCD patients with and without OCPD did not differ in sex, age of onset, or duration of illness. While these studies are of interest in attempting to understand the interface of OCD and OCPD, we must be cautious in interpreting the results. As Jenike has stressed, making the diagnosis of a personality disorder in the presence of a major Axis I disorder such as OCD is often misleading. His group found that about 80% of OCD patients with associated personality disorders no longer had the Axis II diagnosis after successful treatment for OCD. This finding raises the possibility that the current diagnostic criteria may be problematic in that they are not specific enough for OCPD to be diagnosed with confidence. Indeed, some criteria for OCPD are highly controversial. As Randy Frost emphasized at the OCF 2000 Schaumburg meeting last August, hoarding, which is included in the DSM-IV criteria for OCPD, actually does not appear to correlate with the other criteria, with the possible exception of perfectionism.

CONCLUSIONS

Given the current state of knowledge about the interface of OCD and OCPD, what can we conclude that is useful for clinicians and consumers alike? First, while OCD and OCPD have similar sounding names, they are probably unrelated. Second, persons with OCD may have a number of different personality disorders, and OCPD is not the most frequent. Third, when someone is suffering from severe OCD, the symptoms may mislead clinicians to overdiagnose personality disorders, and with improvement the diagnostic criteria for the personality disorder may disappear. Fourth, different biopsychosocial mechanisms probably account for OCD and OCPD. Fifth, while OCD responds well to medication and behavior therapy, OCPD does not. Conversely, OCPD appears to improve with psychodynamic therapy, but OCD does not. Sometimes a psychodynamic approach may be helpful for relationship problems and resistance to taking medication or practicing behavioral techniques in some OCD patients, but the rituals and obsessional thoughts are not likely to improve. Finally, when an OCD patient has an associated personality disorder, a multimodal treatment plan may be needed, and the treatment is likely to be more prolonged and more challenging.

Entries Sought for Conference Art Show

At the 8th Annual OCF Conference in Denver, July 20-22, there will be an Art Show and Contest. The Show and Contest are being sponsored by Patrick Johnson, a long-time OCF member, who has been the guiding spirit behind the art displays at previous OCF Conferences.

Patrick has donated prize money for this year's Show and Contest. The following is an interview in which he sketched out his beliefs about the healing effects of art on both the creator and the audience.



Patrick Johnson, sponsor of this year's Conference Art Show, with Grover Hogan, who displayed some of his work at last year's Conference.

NEWSLETTER: You're the chairman for the Art Show and Contest at the 8th Annual OCF Conference in Denver. Can you tell our readers a little about it?

JOHNSON: This year our goal is to make the Art Show an important part of the Conference. We're making it into a contest as well as expanding the types of artistic expression that we are going to showcase.

First, the show and competition are not going to be limited to the visual arts. We are inviting participants to submit essays, short stories, poetry, films, videos and musical CDs as well as paintings, sculptures, collages, and prints. We want to showcase all the talents of individuals who are interested in or affected by mental illness.

There will be three prize categories: Children (age 12 and below), Adolescents and Young Adults (ages 13 to 22) and Adults. There will be three prizes in each category. We are not breaking the categories down by genre. So, the first prize in a category could be for an essay or short story; second prize could be for a watercolor and third prize could be a CD of an original song.

NEWSLETTER: Why are you sponsoring the Show?

JOHNSON: I want to encourage the artistic expression of people who are interested in or affected by mental illness. Not just OCD, any mental illness. I think that people who have more than a passing acquaintance with mental illness have a unique perspective on life and that through art they can express this different way of seeing things. I think people who are on intimate terms with mental illness have something important to say and I

want to encourage them to make their statements and reward them for doing so. Artistic expression enriches everyone.

NEWSLETTER: Are you planning an exhibit at the Conference?

JOHNSON: Yes. We are talking with the hotel people to find a space to use as a gallery. We want to be able to display all the work that is submitted throughout the Conference. We want the attendees to be able to view it and be inspired by it. We are tentatively planning to announce the prizewinners Saturday night at the Reception.

NEWSLETTER: Who can submit work for the Show and Contest?

JOHNSON: Anyone who has been affected by a mental illness and is a member of the OCF Foundation. They don't have to attend the Conference to be able to submit their work. Of course, it would be so much better to have the artists there, but we understand that someone might not be able to attend. We don't want to limit participants by saying that they have to be at the Conference to win a prize.

NEWSLETTER: What can an entrant submit?

JOHNSON: We are looking for works of art and by that I mean anything created: a poem, a painting, a sculpture, a film. Of course, we are limited by space, technology and shipping considerations. Anyone who enters a work will be responsible for getting it to the Conference and responsible for it while it's there. We won't be able to insure anything or ship anything. Each artist will be responsible for securing and paying for any equipment needed to display a piece, such as, a monitor or a compact disk player. Participants will also be responsible for getting their work home.

NEWSLETTER: What are the prizes?



Art work displayed at the 7th Annual OCF Conference.

JOHNSON: The first prize in each age category is \$250. The second prize in each category is \$50 and the third prize is \$25.

NEWSLETTER: How are prizewinners going to be determined?

JOHNSON: We are going to have a panel of judges who will review the entries and vote. They'll announce the winners at the Reception

Saturday night.

NEWSLETTER: What do you have to do to enter the Show and Contest?



Art Display at the Chicago Conference.

JOHNSON: We've prepared an application blank with all the necessary information and the rules. Anyone who is interested can call the Foundation at 203.315.2190 and request an application. People can also e-mail the Foundation at cole@ocfoundation.org or download a copy of the application from the OCF website-www.ocfoundation.org. There is a \$10.00 application fee for each piece of art. The fee along with the application and the work if it's a writing, CD or film or a photograph, if appropriate, must be submitted to Jeannette Cole, Deputy Director, at the Foundation by June 15, 2001.

NEWSLETTER: Does the work have to express an OCD theme?

JOHNSON: No. It can. But I think that this Show is an important way to give people affected with mental illness a chance to show that mental illness doesn't define them, it just challenges them. We are looking for works that express what it means to be human, to love, to suffer, to endure, to overcome, to laugh. In other words, art about anything and everything.

NEWSLETTER: You said participants can submit writings too. What types of written works can be submitted?

JOHNSON: The committee is looking for artistic expression in writing. We've put a word limit on submissions because this is an Art Show and we want the work to be easily accessible to the patrons. Essays cannot exceed 1,000 words. Short stories are limited to 2,000 words and poems should be no longer than 1,000 words. These can be illustrated if someone chooses.

The deadline for all writings is June 15, 2001. This will allow sufficient time for the judges to read each work before voting.

NEWSLETTER: Patrick, what would you say to encourage people to participate?

JOHNSON: That's simple. Here's a chance to show everyone who you are and what you can do. Don't miss it.

New Program Opens at Mayo Clinic

The following is an interview with Jonathan Abramowitz, Ph.D., director of the new OCD/Anxiety Disorders program at the Mayo Psychiatry and Psychology Treatment Center at the St. Mary's Hospital Campus in Rochester, Minnesota. Dr. Abramowitz was formerly associated with the Center for the Treatment and Study of Anxiety at the University of Pennsylvania. This is the third interview in this series describing programs where OCD sufferers can receive intensive treatment.



Home of the OCD/Anxiety Disorders Program at the Mayo Clinic.

NEWSLETTER: Tell me about your program at Mayo? Is it a brand new program, or are you building on an already established program? Is it just for OCD and the Spectrum Disorders or is it for all Anxiety Disorders?

ABRAMOWITZ: Mayo's OCD/Anxiety Disorders program is brand new – as are our clinic facilities. We are housed within the Mayo Psychiatry and Psychology Treatment Center at the St. Mary's Hospital Campus in Rochester, Minnesota. The program will aim to treat people with OCD, as well as those with other anxiety disorders (panic, phobias, post-traumatic stress).

NEWSLETTER: Until recently you have been on staff at the Center for the Treatment and Study of Anxiety at the University of Pennsylvania. Will your Mayo program employ the intensive behavior therapy program designed by Dr. Foa?

ABRAMOWITZ: Edna Foa's intensive cognitive-behavior therapy protocol involving exposure and response prevention will be the staple of our OCD treatment program. This 3-week outpatient program has been shown to be highly effective for the majority of patients who complete it. In my three plus years working in Dr. Foa's clinic, I have seen many people with severe OCD regain social, occupational, academic, and leisure functioning following this treatment. We offer the same therapy here at Mayo.

NEWSLETTER: What treatment modalities

will you be using to treat OCD and the Spectrum Disorders at your new program?

ABRAMOWITZ: Keeping up to date on the latest research on treatment of OCD is a priority of mine. There are currently two effective forms of treatment for OCD: 1) cognitive-behavior therapy including exposure and response prevention; and 2) medication with serotonin reuptake inhibitors. Both of these treatments will be available at Mayo. During the initial consultation, patients will learn about the available treatment options and what is recommended for them.

Our program offers new treatment procedures that have been shown, in the latest research trials, to be effective. For example, there are new and effective cognitive-behavioral programs for "pure obsessional," body dysmorphic disorder, and hypochondriasis.

I have a special interest in "pure obsessions;" i.e., where a person has scary obsessional thoughts, such as, fearing that he or she might hurt someone, but no overt compulsions like washing or checking. This problem once baffled psychologists and was considered resistant to treatment; but newly developed treatments by colleagues in Canada and England can be very effective in helping people overcome their frightening obsessional thoughts.

NEWSLETTER: Besides behavior therapy/exposure and response prevention, will medication therapy be available for patients who come to your Treatment Center?

ABRAMOWITZ: Indeed. Some patients with OCD seem to respond best to a combination of cognitive-behavior therapy and medication. We have physicians (psychiatrists) on our staff who will oversee medication treatment.

NEWSLETTER: Is your program going to feature intensive behavior therapy? Will there be non-intensive treatment also?

ABRAMOWITZ: Good question! For patients within commuting distance, we will also offer less intensive treatment regimens, such as "twice-weekly" therapy.

A study I recently completed in collaboration with my colleagues at the University of Pennsylvania suggested that OCD often responds well to less intensive cognitive-behavior therapy. However, we will evaluate each individual patient before deciding on a treatment schedule, because there are some factors that we think influence whether intensive or less-intensive treatment is the best alternative. For example, less severe compulsions and favorable family support may predict more success with less intensive treatment. A recommendation about intensive vs. less intensive treatment will be made following a thorough initial evaluation.

NEWSLETTER: Are you offering in-patient treatment as well as outpatient treatment?

ABRAMOWITZ: At this time, we are offering only out-patient treatment. However, we are working toward an inpatient program for the future and will certainly publicize the opening of such a program.

NEWSLETTER: If you don't have in-patient facilities, what provisions for treatment at your Center can someone from out of the area make?

ABRAMOWITZ: Rochester, Minnesota is a city of over 100,000 people, located in the southeast corner of the state, about one hour from Minneapolis/St. Paul, and 6 hours from Chicago and Milwaukee. Rochester has a new airport with numerous flights daily from Minneapolis and Chicago. There are many hotels that have special "Mayo Clinic Rates" for



John Abramowitz, Ph.D.

patients and their families. Indeed, Mayo is the main attraction in Rochester. We have lists of places to stay during treatment that we will send out upon request. There are several nice restaurants and two

shopping malls within the city. In addition, the downtown buildings (including most hotels) of Rochester are connected by an impressive series of subways and skyways. So, in the bad weather, one never has to go outside to get around town. By the way, Rochester is consistently ranked among the top 3 places to live in the USA!

NEWSLETTER: Will you be treating children and adolescents as well as adults?

ABRAMOWITZ: We will have the capabilities for evaluating and treating adolescents and children with OCD.

NEWSLETTER: How long typically is your intensive behavior therapy program? What does it involve exactly?

ABRAMOWITZ: Our intensive behavior therapy program is about three to four weeks in length and involves three phases: 1) information gathering; 2) exposure and response prevention; and 3) relapse prevention. Each patient's treatment program is highly individualized and tailored to the specific OCD symptoms that need to be addressed.

(continued on page 9)

2001 Research Award Winners Announced

(continued from page 1)

Pauls, Ph.D., professor at the Child Study Center and Department of Psychology, Yale School of Medicine. Pauls is a leading researcher in the field of genetics.

Pauls sees this study as really critical. "I believe that results from this work will inform future genetic analyses for OCD," he said in recommending it for funding.

Through her study, Rosario-Campos hopes to better understand the inherited phenotype. In describing her project, she explained that the only way to determine which genetic factors are involved in OCD is through the correct identification of familial traits.

Her goal is to clarify the relationship between Tourette's Syndrome, OCD, ADHD and other possibly related disorders and to further refine the scientific community's understanding of the factors that have been identified for both TS and OCD.

Rosario-Campos' study, according to Jenike, is significant because it is the first OCD segregation analysis done in a sample population discovered by its relationship to children and adolescents with OCD.

"Developing a Cognitive Rehabilitation Program for OCD" – Carey Savage, Ph.D.

Dr. Savage, who received his undergraduate degree magna cum laude from the University of North Colorado in 1986, was awarded a Ph.D. in Clinical Psychology from Oklahoma State University in 1991. From 1992-1994, he was a psychiatric neuroscience fellow at Massachusetts General Hospital.

In 1999, Savage won the NARSAD Young Investigator Award. He is presently on the editorial board of the *Journal of Geriatric Psychiatry and Neurology* and the chair of the National Institute of Mental Health's Special Emphasis Panel and an external reviewer for the Department of Veteran Affairs Merit Grant Program.

The co-investigator on this grant is Sucheta Kamath, M.A., who is presently a cognitive rehabilitation specialist and staff speech and language pathologist at Massachusetts General. Kamath developed "Steps to Success," a six-week outpatient cognitive rehabilitation program for adults and adolescents with mild brain injuries who want to pursue academic, professional or vocational goals.

Kamath has a master's degree in Speech Pathology from Ohio University and a master's degree in Linguistics from the University of Bombay. She is board certi-

fied in Neurogenic Communications Disorder by the Academy of Neurogenic Communications Disorders.

The specific aim of "Developing a Cognitive Rehabilitation Program for OCD," according to Savage is to investigate the effectiveness of a cognitive rehabilitation program in a group of patients with OCD. This type of program might help to alleviate the OCD symptoms that either medication or cognitive behavior therapy have not been able to eliminate, says Savage.

While working in this field, Savage noticed that many OCD patients had memory impairment. At the same time this was becoming apparent, advances in functional neuroimaging were producing data that tied memory functions to the orbitofrontal cortex. This region has been implicated in neurobiological theories of OCD.

The project we are proposing, said Savage, seeks to investigate the effectiveness of a cognitive rehabilitation program in a group of patients with OCD. Specifically, we plan to study the effectiveness of a clinical intervention designed to teach OCD patients to use organizational strategies to improve their ability to encode and retrieve memories.

"This innovative study," says Baer, "will attempt to develop a rehabilitation treatment to help individuals with OCD to surmount memory problems that appear to be part of their OCD. The subcommittee considered this an important project."

"Relation of the Serotonin Transporter Gene to OCD" – Thomas Joiner, Ph.D.

Joiner will be the principal investigator on this project, joined by Frank Johnson, Ph.D. as co-principal investigator.

Joiner graduated from Princeton with a BA in psychology in 1987 and received his Ph.D. in clinical psychology from the University of Texas at Austin in 1993. He is presently professor and director of the University Psychology Clinic, Department of Psychology at Florida State University. Joiner, who has published 129 articles, chapters and letters, is a member of the NIH Review Panel, is an Elected Fellow of the American Psychological Association and won the APA Distinguished Scientific Award for Early Career Contributions to Psychology in the Area of Psychopathology in 2000.

Johnson received his Ph.D. in psychobiology in 1989 from the University of California, Riverside, and did post-doctoral work in Neuroscience at the University of Southern California. His major area of research interest is the role of gene expression in neural and behavioral development. He is currently assistant professor,

Department of Psychology at Florida State University. Johnson directs the FSU Molecular Neuroscience Laboratory.

Their project, "Relation of the Serotonin Transporter Gene to OCD," is designed, according to Joiner, to study the role of the serotonin transporter gene by examining the relation of current OCD and OC symptoms to the gene's allelic variations.

"Dr. Joiner's study," says Baer, "will look at a candidate gene, the serotonin transporter gene, to determine how large is its role in OCD. It was chosen because it was "carefully planned and could provide very important leads in understanding the mechanisms causing some forms of OCD," added Baer.

"It was hard to choose among the 17 proposals submitted," according to Emmerman. "As you can see, we looked for a balance among genetic studies, treatment possibilities and basic science. There really was a wide range represented by the applications we received. The choice was difficult because of so many excellent applications from such varied fields."

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IDEA: A PRIMER FOR PARENTS (continued from page 3)

in the regular classroom, with supplementary aids and services as needed, whenever possible.

Parent and Student Participation

IDEA requires that the schools solicit and consider the opinions and desires of a student's parents as well as provide them with appropriate notice of actions taken pursuant to IDEA and obtain the consent of the parents for those actions. Student participation is encouraged when appropriate and is, in fact, required when transition services to the working world or higher education are involved. At all times, however, the student's individual preferences and interests must be taken into consideration.

IDEA is a powerful support for students with disabilities and their parents. Sometimes, however, getting schools and school districts to follow through on the requirements of the law may be difficult. Unfortunately, the typical problems-and their possible solutions-encountered by parents in dealing with the schools under IDEA are beyond the scope of this article.

Edward N. Matisik, J.D. is an attorney in Washington, D.C. specializing in education, disability, and non-profit law.

Research Digest

Selected and abstracted by Bette Hartley, M.L.S. and John H. Greist, M.D., Madison Institute of Medicine

Abstractors' Comments:

Serotonin reuptake inhibitor (SRI) medications (citalopram [Celexa], clomipramine [Anafranil], fluoxetine [Prozac], fluvoxamine [Luvox], paroxetine [Paxil] and sertraline [Zoloft]) provide substantial relief for individuals suffering from OCD. These medications need to be tried for up to 12 weeks, at adequate dosage, to evaluate their helpfulness. Once an effective medication is identified, duration of treatment is an important question. Relapse is common when effective medication is stopped, even after a year or more of treatment.

Behavior therapy for OCD is effective when used alone and often produces further improvement when combined with an SRI. There is evidence that some who add behavior therapy to an SRI are then able to stop their medication without significant relapse. Unfortunately, skilled behavior therapists are seldom available and many individuals must continue these medications for years to maintain their gains.

Fortunately, there are no data indicating dangerous adverse effects with long term use of SRIs. The following two papers are relevant to these issues.

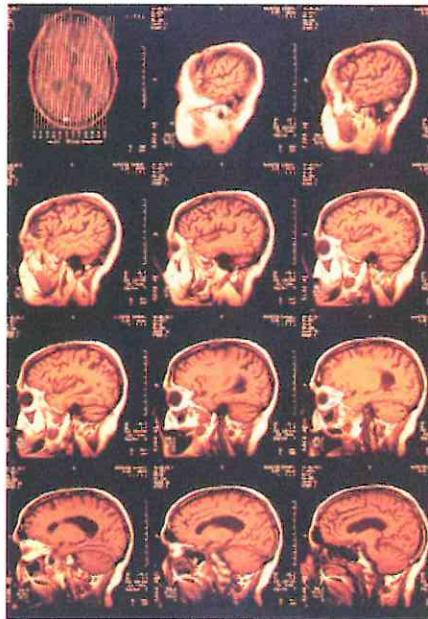
The following is a selection of the latest research articles on OCD and related disorders in current scientific journals.

Long-term treatment of obsessive-compulsive disorder after an acute response: a comparison of fluoxetine versus placebo

Journal of Clinical Psychopharmacology, 21:46-52, 2001, S. Romano, W. Goodman, R. Tamura, J. Gonzales and the Collaborative Research Group

Few controlled studies have evaluated the long-term continuation of drug therapy for relapse prevention in patients with OCD. This study assessed effectiveness and safety of fluoxetine (Prozac) versus placebo in preventing relapse of OCD during a 52-week period in responders to short-term, 20 weeks, fluoxetine therapy. Patients who continued treatment with fluoxetine at 60 mg/day had significantly lower rates of relapse than those who were switched to placebo. Patients who responded to fluoxetine doses of 40 or 20 mg/day and continued those doses also had low overall rates of relapse, but the difference in relapse rates between fluoxetine-treated and placebo-treated patients was not statistically significant. Analyses of adverse effects, vital signs and clinical laboratory data indicated that fluoxetine was safe and well-tol-

erated over the 52-week period. The current study represents the largest drug therapy relapse prevention trial to date. The fact that continued treatment with fluoxetine did not reveal increased response beyond the point reached during the first 20 weeks of treatment, suggests the benefit of a multimodal therapeutic approach. Based on the findings of this study, consideration should be given to administering fluoxetine for up to 1 year to those patients who responded to initial treatment with addition of cognitive behavioral treatment to increase response, if skilled cognitive behavioral thera-



pists can be found.

Relapses after discontinuation of drug associated with increased resistance to treatment in obsessive-compulsive disorder

International Clinical Psychopharmacology, 16:33-38, 2001, G. Maina, U. Albert and F. Bogetto

The majority of follow-up studies of OCD patients indicate that drug discontinuation leads to the recurrence of OCD in most patients (23-89%). The aim of this study was to determine whether OCD patients initially responding to drug therapy and who relapsed upon drug discontinuation would respond again when given the same drug at the same daily dose. Of 183 patients responding to treatment with clomipramine (Anafranil), fluoxetine (Prozac), fluvoxamine (Luvox) or paroxetine (Paxil), 44.8% relapsed within 6 months of drug discontinuation. In the majority of these patients, OCD

symptoms returned within the second month of discontinuation with the exception that most patients who were on fluoxetine relapsed after the third month of discontinuation. Results indicate that patients whose symptoms recur after drug discontinuation respond again when the same drug used previously (at the same dosage) is used, but the degree of response was less for some patients. This implies that some patients were more resistant the second time around and suggests that the increasing resistance may be a product of the passage of time in OCD or, alternatively, a product of additional episodes. Researchers suggest that their findings of possible lowered response after discontinuation and high relapse rates upon discontinuation support continuing medication treatment in OCD over the long term.

A double-blind comparison of fluvoxamine versus placebo in the treatment of compulsive buying disorder

Annals of Clinical Psychiatry, 12:205-211, 2000, D.W. Black, J. Gabel, J. Hansen et al.

Case reports have suggested that patients with compulsive buying improved when treated with selective serotonin reuptake inhibitors (SSRIs). Open label trials of fluvoxamine (Luvox) and citalopram (Celexa) have also supported the use of SSRIs. In contrast to these promising case reports and open label trials, this double-blind placebo controlled study found equal responses to fluvoxamine and placebo. This is the second placebo controlled investigation of the effectiveness of fluvoxamine in the treatment of compulsive buying disorder. We presented results from the earlier study in the OC Foundation Summer 2000 newsletter (Journal of Clinical Psychopharmacology, 20:362-366, 2000). It is of interest that both controlled studies found the medication was not more effective than the placebo. It could be that longer trials are necessary, response was only measured for 9 to 12 weeks in these studies. Most importantly, both studies had high placebo responses that could be attributed to the benefits of education and activities such as record keeping diaries to increase awareness of compulsive shopping behaviors. Further investigation of behavioral treatments of compulsive buying is warranted, including the use of simple measures such as maintaining shopping diaries.

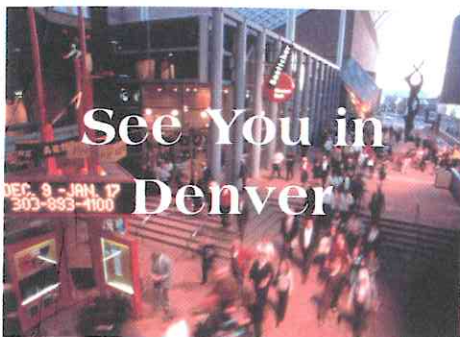
Symptoms of eating disorders in obsessive-compulsive disorder

Acta Psychiatrica Scandinavica, 102:449-453, 2000, H.J. Grabe, A. Thiel and H.J. Freyberger

Previous studies have found high rates of obsessive-compulsive symptoms or personality traits in patients with eating disorders. It has also been hypothesized that eating disorders are related to OCD as part of the obsessive compulsive spectrum. Eating disorder symptoms and OCD symptoms are compared between 61 patients with OCD and 288 healthy control subjects. The OCD patients were found to have significantly more eating disorder symptoms than controls. The results also identified a gender difference in that OCD symptoms were associated with core eating disorder symptoms in females, but not in males.

Hair pulling in African Americans—only your hairdresser knows for sure: an exploratory study *Cultural Diversity and Ethnic Minority Psychology*, 6:352-362, 2000, A.M. Neal-Barnett, B.J. Ward-Brown, M. Mitchell et al.

The authors examined whether African American hair care professionals saw individuals with trichotillomania, chronic hair pulling, that results in significant hair loss. Thirty eight African American hairdressers and 1 Caucasian hairdresser were interviewed about their customers' hair-pulling behavior. These hair care professionals saw 27 individuals who met general criteria for trichotillomania. Interestingly these hair care professionals attributed the hair pulling behavior to bad nerves, stress, habit, and worry. Hair care professionals appeared skilled at treating the consequences of chronic hair pulling (camouflaging the bald areas). Two customers were offered assistance for the actual hair pulling; these customers were advised to wear mittens and stocking caps at home. Researchers believe the relationship between African American women and their hairdressers coupled with the emphasis placed on hair in the Black community would make African American women more likely to seek some remedy for the hair pulling. They also believe that African American hairdressers can play an important role in educating and informing their communities about trichotillomania. To this end, they have developed a community education program. As part of this program they have produced a video and put together a free Continuing Education workshop for licensed hair care professionals about trichotillomania. The goal is to familiarize hair care professionals with the disorder and the help that is available.



Denver Center for the Performing Arts

New Program Opens at Mayo Clinic

(continued from page 6)

During the "information gathering" phase (about 3 sessions), details about the patient's history, family, and obsessions, compulsions, and avoidance, are discussed in a way that will help the therapist to develop a treatment plan. The therapist and patient also discuss how the treatment will proceed and together design a hierarchy of the patient's feared situations and thoughts. An important aspect of this part of therapy is that while the therapist is learning about the patient's specific OCD symptoms, the patient is learning how cognitive-behavior therapy will help to weaken OCD symptoms.

During exposure and response prevention (about 15 sessions) patients practice confronting the previously identified situations that evoke obsessional fears. This is "exposure." Therapists also help patients to refrain from compulsive rituals "response prevention." This is the most challenging aspect of treatment because most patients feel uncomfortable confronting things they have spent a lot of their time and energy trying to avoid. Importantly, the therapist closely supervises exposure and helps the patient when difficulties arise. Also, easier situations are practiced before gradually moving toward more difficult ones. No patient is ever forced to do an exposure. This is a voluntary treatment. However, research suggests that improvement is strongly related to the amount of practice. I often tell patients I work with that: "it's worth experiencing anxiety now, in order to have a calmer future."

For patients within driving distance of Mayo, the relapse prevention phase of treatment includes six sessions spaced as necessary (one per week, once per month). Patients work on gradually decreasing their avoidance of everyday situations and practicing difficult exposure situations with the therapist. For patients who have traveled to Mayo from long distances, this phase may include a therapist home visit, where the therapist goes to the patient's hometown and works with the patient in his/her environment.

NEWSLETTER: Do you have a separate regimen for treatment refractory patients?

ABRAMOWITZ: For patients who have failed to respond to cognitive-behavior therapy in the past, we will assess the course of their treatment to determine whether more intensive therapy is recommended, or whether additional trials of medication or other forms of treatment (e.g., inpatient) would be best.

NEWSLETTER: Are you going to have support groups for past and present patients?

ABRAMOWITZ: Indeed. We are working to organize a local OCD support group that will meet regularly.

NEWSLETTER: How many patients do you expect to be able to treat at one time? How big a staff will the clinic have?

ABRAMOWITZ: Presently, we have four full-time cognitive-behavioral therapists and two psychiatrists associated with our program. We

are considering adding another therapist. This means we can treat several people with OCD at one time.

NEWSLETTER: Can you tell us about your background? Where did you do your undergraduate work? Your graduate work? Your post doctoral work?

ABRAMOWITZ: I was born and raised in Baltimore, MD (Go Ravens!) and received my undergraduate degree from Muhlenberg College in Allentown, PA. I received my Ph.D. in Clinical Psychology from the University of Memphis in Tennessee. Following graduate school, I completed a post doctoral fellowship at the Center for Treatment and Study of Anxiety (University of Pennsylvania). In November of 2000, I was hired by Mayo Clinic to develop an OCD and anxiety treatment and research program here.

NEWSLETTER: Will your clinic take private insurance? Medicare? Medicaid? Will there be any provisions for individuals who can't afford the program?

ABRAMOWITZ: Because of the diversity in insurance coverage, it is best to telephone Mayo to find out about financial arrangements. I am happy to speak to people with questions regarding insurance and fees. My phone number is (507) 284-6145.

NEWSLETTER: You have done a great deal of research during your career, will you be continuing to do research at Mayo? What areas of research do you anticipate being involved with?

ABRAMOWITZ: I have several research interests that I plan to continue at Mayo. Primarily, I am interested in improving treatment for OCD and making this therapy more widely available in clinical settings. We have an effective treatment in exposure and response prevention, but it does not help everyone, and it is not available everywhere. I am planning research to develop programs that will help patients get ready to do this treatment, to design therapies that will address patients-family interactions, and to devise training programs for new therapists. One project we are excited about is the development of a treatment program for people with OCD and severe depression. We have applied for a grant to fund this study and hope to begin enrolling participants later in 2001.

NEWSLETTER: Will you be doing research studies with patients where they will be treated for free?

ABRAMOWITZ: Yes, We hope to be able to treat patients who are eligible for research for free.

NEWSLETTER: Will you have the facilities to handle someone whose OCD is so serious that he needs hospitalization?

ABRAMOWITZ: Mayo has a psychiatric inpatient program that can handle patients with symptoms so severe that they require hospitalization.

(continued on page 11)

From the Foundation

(continued from page 1)

Jonathan Grayson, Gayle Frankel, AnnaMae Yurkanin and the Philadelphia G.O.A.L. Group.

The most difficult problem after choosing the presentations is fitting them into a time slot. Hillary, reading directly from her event-planning textbook, suggested that we use the "Spider Technique." That's where you find a pivotal presentation, put it in the center and then work out from it. Sounded like pretty good advice. But what do you do when you've got at least 15 presentations that could be the centerpiece? RIP. Down comes another heavily marked up sheet of paper to be added to the program-planning file on the floor.

When the Planning Group met in November, we decided to run separate tracks this year—one for individuals with OCD, one for families and kids and one for professionals. That seemed like a good concept to base our schedule on. However, there was one other problem. Some of our lecturers are also going to be presenting at the World Congress in Vancouver, which runs through our opening day. Unfortunately, while some of our presenters have performed what looks like treatment miracles, none of them have achieved the saintly attribute of bilocation, yet. Another perfectly rectilinear program grid lands in the trash.

After many trips back to the drawing board, we came up with a plan for Friday that includes a Newcomers' Orientation and a Children and Adolescents' Orientation on Friday morning. These are new features whose purpose is to acquaint first-time Conference attendees with an overview of OCD and its treatments as well as the nuts and bolts of the Conference itself.

For families, we going to have a two-part forum: "Family Responses to OCD: A Transactional Perspective" by Barbara Van Noppen, MSW, followed by a panel discussion with Questions & Answers, "Support, Empathy & Enabling: How Should A Family React?" While these workshops are going on, there will be special sessions for children and adolescents as well as supervised "Hospitality Rooms" where they can do art and writing projects, listen to music or just socialize.

Throughout the weekend, there will be five or six sessions running simultaneously in every time slot. On Friday, to name just a few, there are sessions on Medication Augmentation, Diagnosis and Treatment of OCD in Children & Adolescents, a CBT workshop for kids, a relapse prevention seminar, Exposure and Response Prevention without a therapist, Dr. Jeffrey Schwartz on "mindfulness" as well as Lee Baer introducing "The Imp of the Mind."

We used a sardine can as our scheduling model for Friday night. There will be an OCA support

group, a G.O.A.L. Group, a parents' presentation, support group and social hour; a mocktail party for the kids and a panel on "Transitions" for and by the older teens and young adults. To cap off the night, the Philly G.O.A.L. group with master camper, Jonathan Grayson, Ph.D., will hold the 2nd Annual Virtual Camping Trip. Since, no one was arrested last year, we decided it was safe to do this again.

Pierre Blier, MD, from the University of Florida is this year's Keynote Speaker. The title of his presentation is "Understanding the Mechanism of Action of Serotonin Reuptake Inhibitors: A Step Toward More Effective Pharmacotherapies." Dr. Blier will be illustrating his talk with animation developed in conjunction with Disney Studios. This will be on Saturday morning, early.

There are 12 sessions scheduled for Saturday morning, including workshops and seminars on herbal medicines, co-morbid conditions, and body dysmorphic disorder, genetics and OCD, trichotillomania and impulse control disorders.



What? Me Worry?

On Saturday afternoon, there is going to be a two-part session on Scrupulosity moderated by Alec Pollard, Ph.D. The first part will feature a panel of therapists and clergy, who after offering a theoretical framework for scrupulosity as OCD, will respond with possible solutions to particular scrupulosity problems posed by the audience. In the second session, the panel will work with practicing therapists to design treatment solutions for actual situations their patients face.

Michael Jenike, MD, is going to do a Question and Answer Session on Medication and Treatment, while others will be presenting on school accommodations, hoarding, CBT for kids with comorbid conditions and spectrum disorders among other topics.

Our lawyers willing, we're hoping to have a pool party for the kids on Saturday afternoon.

There will be a Reception on Saturday night with the raffle drawing and presentation of the Art Show awards. After that, there's going to be a Film Festival featuring the premier of the Documentary on OCD done for the Discovery Channel. John Metherell, the producer, is going to talk about making the show. Then, we'll be screening several films made by young people with OCD.

The Conference isn't slowing down on Sunday. Jeannette has reserved Denver 3, 4, 5 and 6 with a capacity of 400 people for David Shannahoff-Khalsa's two-hour workshop on "Yoga and OCD." Last year we put him in a room that only held 125 sitting motionlessly. We won't make that mistake again.

For therapists, there will be a panel on "Imaginal Exposure Script Writing," while Michael Jenike leads a workshop where families and professionals will be invited to brainstorm on getting reluctant people into treatment. There is also going to be a panel on forming and maintaining a successful support group, along with seminars on improving school performance, pregnancy and OCD, and introducing children to CBT.

Along with the Orientation Sessions to help people acclimate, we're going to have "Ask Me" volunteers – people with OCD and family members who have been to previous OCF Conferences. This service is being organized by Charley Schatz, MD, who has written about his experiences as a first time attendee. Readily identifiable by their prominently displayed "Ask Me" badges, these people will be available throughout the Conference to answer questions, make suggestions on sessions and just generally point the way. If you're interested in being an "Ask Me" volunteer, e-mail Daisy at sanchez@ocfoundation.org. She's the one taking names. She and the Doans, of course, will reprise their signature roles at the Bookstore.

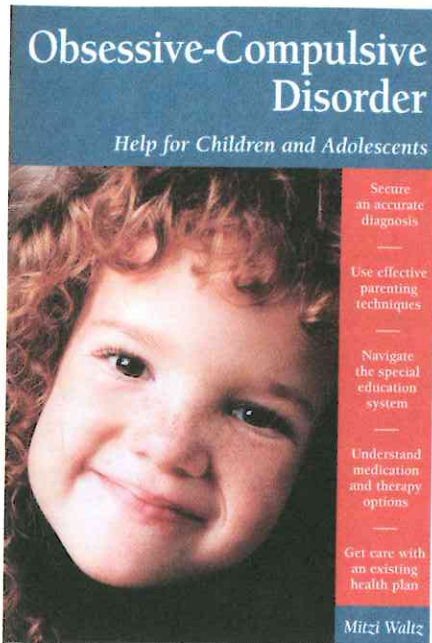
To entice volunteers, Daisy is offering a \$25 rebate off the registration fee to attendees who volunteer and are selected. Anyone who is interested must be able to attend a training session on Thursday evening and be willing to answer questions throughout the whole weekend.

Whew. There you have some of it. Now I've got to go back to trying to squeeze everything known about OCD into three days.

Ciao!

Patricia Perkins-Doyle
Executive Director

Book Review



Obsessive-Compulsive Disorder: Help for Children and Adolescents

Written by Mitzi Waltz

Reviewed by: Aureen Pinto Wagner, Ph.D., who is a Clinical Child Psychologist and author of *Up and Down the Worry Hill: A Children's Book about Obsessive-Compulsive Disorder and Its Treatment*.

Most parents of children with OCD are introduced to the disorder with a similar script: This strange, bizarre illness comes on with brutal force, taking control of their child in baffling and frightening ways. The child is distraught, the parents are caught off guard, and feel helpless as they watch their child become a different person. It's a crisis. Parents desperately seek help in understanding this disorder, looking anywhere and everywhere for direction about the right treatments, and the myriad of parenting, social, academic, health care, financial and support problems that OCD forces upon them.

Mitzi Waltz' book will change this script so that parents do not have to spend countless hours piecing together fragments of information about OCD. This well-written book is a comprehensive one-stop shop that covers diagnosis, caus-

es and treatments, alternative and holistic approaches, insurance, healthcare and school issues for children with OCD. As a childhood OCD sufferer herself, and the parent of two children with OCD, Ms. Waltz brings to the book the unique perspective of a parent living with OCD. As a journalist, author and editor, Ms. Waltz provides a well-researched and consolidated fund of information for "beginner" OCD parents in an easy-to-read style.

Of particular value to parents, I believe, is Ms. Waltz' coverage of practical issues pertaining to advocacy and support for children with OCD. Her chapters on insurance, public health and financial aid programs, and school accommodations will help many parents navigate through the murky logistical waters encountered in these areas.

She also covers extensively the details of various medications for OCD, and with appropriate cautions, discusses the wide range of natural, herbal and holistic approaches about which parents are often eager to learn, but do not find satisfactory answers easily. In addition, she provides a lengthy appendix of resources that includes books, organizations, agencies, treatment centers, and web sites that is a wealth of information at the fingertips.

Ms. Waltz also discusses health care in some English-speaking countries outside the USA, which may be a good starting point for readers outside the US. This is a book for the "smart consumer", and is available by calling Daisy at (203) 315-2190 ext. 13.

Make a Difference! Make a Donation!

You can make a difference in the lives of individuals with OCD. Make a donation to the OC Foundation or its Research Fund now. Consider a lump sum of money, stocks or other assets. Name the OCF as beneficiary of your will, retirement annuity or life insurance policy. Give to the Foundation through your United Way plan, encourage family members to do likewise. There could be a tax benefit in such gifts.

**Contact the OC Foundation
for further information.**

New Program At Mayo Clinic

(continued from page 9)

NEWSLETTER: Will there be family involvement in the treatment process? Will there be support groups for family members or some kind of orientation so that they can help with the E&RP exercises?

ABRAMOWITZ: It is always a plus to have a friend or relative as a support person during treatment for OCD, and we are happy to include these individuals in treatment as clinically appropriate. At the initial evaluation session, support people will be taught all about OCD and its treatment. In addition, we will put them to work and teach them how to help their loved ones to overcome OCD symptoms.

NEWSLETTER: How will you treat people who are "treatment resistant"?

ABRAMOWITZ: Patients will be evaluated in an individual basis. The first step will be to get a full treatment history to be sure that they have received the correct regimens of CBT and/or medication. If the patient has failed with each of these, we will conduct a thorough assessment to determine why there has been no response, and we will attempt to address these problems.

NEWSLETTER: Does a patient have to be referred to your clinic by a therapist or can he/she self-refer? Who is the Mayo admissions person to contact to learn more about your program?

ABRAMOWITZ: I am happy to discuss treatment options with anyone who is interested in our program. Often, patients are doctor-referred, but not always.

NEWSLETTER: Who should come to your program? Anyone with OCD? People with "treatment resistant" OCD?

ABRAMOWITZ: Our mission is to provide the state-of-the-art treatments for OCD to any and all patients as clinically appropriate. I recommend that people who are interested in our program call to consult with me before scheduling an appointment, especially if they are coming from far away. I will want to find out about particular OCD symptoms and treatment histories in order to make recommendations, or tailor the person's experience to meet his/her needs.

NEWSLETTER: Can individuals with co-morbid conditions be treated at your program?

ABRAMOWITZ: The clinical research indicates that a great many people with OCD also have comorbid conditions. Often patients have depression or another anxiety disorder along with OCD. As I mentioned above, together with experts on depression, we are excited to introduce a treatment program for severely depressed OCD patients. Patients with other comorbid problems such as panic, generalized anxiety, Tourette's Syndrome, and social phobia, are also welcome. Our goal is to work to meet the individual needs of each patient.

Jonathan S. Abramowitz, Ph.D.
Mayo Clinic, Dept. of Psychiatry and Psychology
200 First St. SW, Rochester, MN 55905
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