15 Years of Service

OCD Newsletter

1986 to 2001

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Research is the Key - An Appeal from Dr. Jenike

Hello,

This past year was once again one of unprecedented achievement for the national OC Foundation. Patti Perkins-Doyle, one of the founders of the Foundation, for the second year continued to serve as Executive Director, and Janet Emmerman remains as president. The OC Foundation is clearly on a roll. Major fundraising efforts are underway, and there have been some successes in raising monies for research into OCD and related disorders.

Only the sufferers and their families can understand the true pain and disability caused by these disorders, and we need your educated help in raising money for this year's research grants. I continue to be approached by many researchers throughout the world about whether or not significant funds will be available to help them study OCD and related disorders.

The interest is there, and now it is up to us to help raise the funds to keep them working for our cause. The more money we are able to raise, the more likely brilliant young people will gravitate towards doing research into these potentially crippling disorders.

For the last few years, I have made a plea for help regarding the research funding efforts of the OC Foundation. I heartily thank those of you who responded. Last year I noted that the funds raised previously were quite modest.

From December 1999 through November 2000, we raised $112,916. This included $26,975 from Joy Kant's fundraiser that was discussed in the OC Foundation Newsletter. From December 2000 through today, we have raised almost double that amount.

This is certainly a significant improvement, but when you think that OCD affects over 5 million people in the US alone, this still seems like a trivial amount. If we raised only one dollar per patient, we should have many times this amount. Any amount you can spare would help us greatly.

With the monies that are raised, the OC Foundation funds research proposals that are submitted by talented researchers around the world. Members of the OC Foundation's Scientific Advisory Board rank the proposals to

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OCD — After the Attacks

OCD and Terrorism

Jonathan Abramowitz, Ph.D., Carlene Martin, Mayo Clinic, Rochester, MN

The recent terrorist attacks within the United States have impacted almost everyone across the country in one way or another. For some of us, our daily lives have been forever changed. For others, there may be a sense of increased vulnerability. Still others may feel increased levels of anxiety and fear. Not surprisingly, people with OCD and other anxiety disorders are at a high risk to encounter difficulties with stress during and in the aftermath of what we are experiencing as a nation. Below, we describe several possible ways in which the recent events may affect people with OCD.

Uncertainty

People with OCD have difficulty with uncertainty, especially in their specific obsessional situations. Scientific studies inform us that obsessional fears (e.g., that one may be contaminated by invisible germs) raise levels of uncertainty; and compulsive rituals (e.g., washing) serve to restore certainty and thereby reduce anxiety or distress.

Terrorism preys on our intolerance of uncertainty about personal safety. Threats of future attacks, discussions about biological or chemical weapons, and the anonymity of terrorists strike at the core of this vulnerability. Indeed, terrorism has claimed the lives of only a tiny proportion of our nation, yet most of us feel a sense of concern or fear for oneself, loved ones, or our nation. The threat of terrorism can be considered a psychosocial stressor for many.

We know that OCD symptoms often become worse when other psychosocial life stressors increase. Therefore, one would intuitively expect people with OCD to experience increased symptoms during this time. Nevertheless, it is difficult to determine the extent to which any given individual will be influenced by the uncertainty of our country's new threat. We have, of course, discussed the matter with patients in our program. Yet, whereas some seem to have been greatly affected (one patient experienced a surge in anxiety and decided not to fly to Minnesota for behavior therapy), others seem to be focused more on their particular OCD concerns. Said one man jokingly, "I wouldn't worry too much about

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From the Foundation

Dear Friends,

I called my best friend from high school recently to wish her a happy birthday. That's what we do now that we're separated by time and space. She's really important to me for many reasons: we shared high school. Which is, as we all know, the forge where all of our life-long hang-ups are made. But more than broken hearts, fears, hope and clothes, we shared "scrupulosity." We didn't know it was scrupulosity then. We just knew that we had to go to Confession a lot. I really mean a lot. During Holy Week our senior year, the priest threw us out. He said he didn't have time for us. There were people with real sins.

I now know that if I didn't have her to share my scrupulosity with, I would have had an acute, unmanageable attack of OCD in high school. That would not have been a good thing because it was the Sixties. Not only weren't there any SSRIs and behavior therapy; no one was diagnosizing it.

Our "birthday chats" have a rhythm and structure all their own. We still have the ability to run our thoughts and sentences together. The same things are still important to both of us and the same things still drive us nuts. This time after talking about kids, siblings, family, we started talking about our shared career – we both became lawyers.

Suffice it to say, it is easy to become disillusioned with the practice of law. There are the obvious reasons: the fact that it resembles hand-to-hand combat; that the ultimate goal is getting more than you deserve; and that its written and spoken language are purposefully unintelligible to everyone except the initiate. We both have strong feelings about the fact that it can wear you out and let you down. We talked

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In This Issue

New Impulse Control Clinic at the University of Minnesota

Impulse control disorders (pathological gambling disorder, kleptomania, trichotillomania, compulsive shopping, skin picking, compulsive sexual behavior) are often grouped under the term "obsessive compulsive spectrum disorders." These disorders have many similarities to obsessive-compulsive disorder. Impulsive behaviors (gambling, shopping, stealing, sex), like OCD compulsions, are often experienced as uncontrollable, are often followed by self-reproach, and are often denied. Furthermore, treatment data suggest that impulse disorders, like OCD, may respond to serotonin reuptake inhibitors. There are some salient differences between the two groups as well; OCD patients are often risk aversive and are less impulsive, on the other hand, patients with impulse control disorders are risk takers and are more impulsive.

Impulse control disorders cause so much suffering, are very common, and yet virtually unknown by physicians, the public, and even those who suffer from these illnesses. They are underrecognized and underdiagnosed, in part, because of secrecy and shame. Preliminary estimates suggest that these disorders as a whole may affect as many as 3-15% of the U.S. population (approximately 8 - 35 million people). These disorders affect people of all socioeconomic strata. They occur in people around the world.

The Impulse Control Clinic at the University of Minnesota treats people with impulse control disorders. This clinic is brand new. It is located at Fairview University Medical Center, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota. Suck Won Kim, M.D. and Jon E. Grant, J.D., M.D. provide medication management and Matt Kushner, Ph.D. provides cognitive behavior therapy for both OCD and impulse control disorders. They currently treat patients in the clinic from all over the country, including children and adolescents.

Two treatments effective for impulse control disorders are medications (for example, selective serotonin reuptake inhibitors and opioid antagonists) and cognitive-behavioral therapy. Patients are educated about their disorders, they learn about the available treatment options and what is recommended for them. The clinic also offers new treatment procedures that have been shown, in the latest research trials, to be effective. The clinic also focuses on treatment-resistant impulse control disorders, and impulse control disorders with co-morbid conditions.

The clinic staff is actively involved in clinical research of impulse control disorders, with a special emphasis on pathological gambling, kleptomania, and compulsive shopping. Clinical studies that provide assessment and medication are ongoing and available to qualified individuals free of charge. Call (612) 627.4879 for more information.

Scared of Exposure?

The Anxiety Disorders Center at The Institute of Living/Hartford Hospital's Mental Health Network is conducting a study of people who are uncertain about beginning cognitive-behavioral therapy of Obsessive Compulsive Disorder (OCD). This intervention is designed to help people with OCD overcome their fears of cognitive-behavioral therapy. At the completion of the study, participants have the option of receiving cognitive-behavioral therapy. The study is open to adults ages 18-65, who have OCD and are not currently receiving psychotherapy. To be in the study, participants have to be able to travel to Hartford, CT.

If you are interested in participating in this study, please contact Dr. Nicholas Maltby at (860) 545-7685 or at nmaltby@harthosp.org.

Help for Adolescents and Adults with BDD

People with body dysmorphic disorder (BDD) worry disproportionately about some aspect of their appearance and this worry causes significant distress or impairment in functioning. This is an underrecognized disorder that often responds to treatment. The Body Image Program at Butler Hospital in Rhode Island, The University of Cincinnati Medical Center in Ohio, and Mount Sinai Hospital in New York are offering a free evaluation for individuals with BDD and free study treatment to those who qualify for one of our treatment studies. Participants will receive up to $275.00 for their participation.

The Butler site also has an interview study for people with body dysmorphic disorder. Participants will receive $50.00 for their involvement.

For more information, contact:
The Body Image Program, RI (401) 455-6466 or www.bodyimageprogram.com
Mount Sinai Hospital, NY: (212) 659-8732 or www.mssm.edu/psychiatry/bdd.html
University of Cincinnati Medical Center, OH (513) 558-3991 or www.clinicaltrials.uc.edu

Do You Live Within Commuting Distance of New York City?

Are you on medication but still have OCD symptoms?
You may be eligible to participate in a research study that would provide cognitive-behavioral therapy and medication at no cost to you.
Please call for more information.
The Anxiety Disorders Clinic
New York Presbyterian Hospital
New York State Psychiatric Institute/RFMH
(212) 543-5367 (IRB#3697)

OCD NEWSLETTER

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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.

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We do not have a professional solicitor. 100% of every contribution is received by the OC Foundation.

FROM THE PRESIDENT — WHAT YOUR RESEARCH DOLLARS ARE DOING

Dear Members,

I want to share with you a letter that we recently received from Dr. Blair Simpson, an Assistant Professor of Clinical Psychiatry at Columbia University, Research Psychiatrist at New York State Psychiatric Institute and OCF Research Award winner. I know that many of you are very aware of the Foundation's Research Program. Each year the OCF awards funds to research scientists whose studies are aimed at the cause, treatment and/or cure of OCD.

Dr. Simpson won her award in 1999 to study the serotonin system in OCD patients. Because of our limited resources, the amount of the award was small when compared to those awarded by agencies such as the National Institutes of Health (NIH). However, as with so many of our grant awards, it provided pilot data for submitting a substantially larger grant proposal to the NIH. Here is her letter:

Dear OCF Members,

I received an OC Foundation Research Award in 1999. I am writing to thank you and tell you how helpful it has been to our OCD research program in the Anxiety Disorders Clinic at the New York State Psychiatric Institute (NYSPI).

It has been hypothesized that people with OCD have a problem with a brain chemical called serotonin, but it has been hard to test this hypothesis directly because of the difficulty of studying the neurochemistry of a living person's brain. Dr. Marc Laruelle's group at the NYSPI is one of the few in the world that has developed ways to visualize the location of specific chemicals in a living person's brain. He uses compounds that bind to serotonin receptors (and other brain chemicals) and visualizes these compounds using advanced brain imaging techniques such as positron emission tomography. My mentor, Michael Liebowitz, and I wanted to examine the brain serotonin system in OCD patients, so we started to collaborate with Dr. Laruelle. However, we needed to raise money for such a novel brain imaging study, given that running a single subject in such a study costs $5,000 to $6,000 for the brain imaging expenses alone. The National Institutes of Health (NIH) funds large grants for clinical research, but requires pilot data to demonstrate the feasibility of a novel approach and the likelihood of an important result; we had no pilot data. There are smaller NIH grants for more experimental studies, but the application process is long. It can take a minimum of one year from submission to funding (and typically takes twice that long given that revisions and resubmission are often required). We wanted to start the work immediately, not to wait 1-2 years. Although some private foundations fund mental health research (e.g., the National Alliance for Research on Schizophrenia and Affective Disorders), none (but the OC Foundation) focuses on funding OCD research.

Fortunately, the OC Foundation exists, and decided to fund our application. Knowing we had money to start, I was able to secure the necessary approvals from my institution and to begin recruiting subjects. Your funding enabled us to examine five subjects, and to obtain the first images of the serotonin transporter in the brains of living OCD patients. I then submitted and was awarded a 5-year Clinical Research Career Development Award from the NIH; this Award has provided me additional research funds with which I can now complete this brain-imaging project. With the NIH money, we have now studied ten OCD and ten control subjects, and are in the process of analyzing the data. The OC Foundation Award made the critical difference in winning the NIH grant, because I had the necessary pilot data to demonstrate the project's feasibility.

I do not yet have the results to tell you what we found, and this project is only a first step towards understanding what happens in the brain when someone has obsessions and compulsions. However, I know that without the OC Foundation Research Award, we would not be as far along as we are now. Thank you and please thank the people who donate funds to the OC Foundation for these research awards.

Sincerely,

Blair Simpson, M.D., Ph.D.
Assistant Professor of Clinical Psychiatry
Columbia University
and
Research Psychiatrist
New York State Psychiatric Institute

In October, the OCF once again issued its Call for Proposals for its 2002 Research Awards. Notices were sent out to the Chairpersons of Psychiatry and Psychology Departments across the country and to anyone who had expressed an interest in OCD research. Initial application must be made by December 14, 2001. Lorrin Koran, M.D., Professor of Psychiatry, Stanford University Medical School, will head this year's Review Committee. The final recommendations will be presented to the Foundation's Board of Directors for funding approval.

We look forward to receiving submissions for projects that will be as effective as that of Dr. Simpson's, projects that if nurtured may lead to the discovery of more effective treatments for OCD.

Dr. Simpson's letter explains why it is so important that the Foundation raise funds for research. There are many sparks of inspiration from many bright scientists that need to be nurtured and directed towards OCD research. The OCF is the only practical source of funding for fledgling OCD research projects.

I wanted you to read Dr. Simpson's letter first-hand so that you could see how important your contributions to the OC Research Fund are. Your donations go directly to front line research. Without funding from the OCF and its members, there would be very little research directed to OCD.

Just think about it! It's not often that you get a chance to really make a difference and impact something so significantly. Please give, even a few dollars, to the OC Foundation Research Fund and help us to attract and support important OCD research.

Thank you.

Janet Emmerman
President, OCF Board of Directors.

The Holidays Are Coming!

Shop for all of your end-of-year holiday gifts at **GREATERGOOD.com**. For whatever you need, GO to the OCD website, HYPERLINK: www.ocfoundation.org
Click on the OCF SHOPPING PLAZA and shop at the more than 80 retailers listed on the GreaterGood.com Shopping Mall.
The OCF has become a partner of GreaterGood.com and will receive up to 15% of the sales price of items bought by shoppers who have registered the OC Foundation as their charity of choice. This amount is donated by the merchants located at the GreaterGood.com Shopping Mall. So, shop until your fingers won't flex anymore!

OC ME - A Play About OCD

Jessica Honor Carlton, now a freshman at Northwestern University, told Dorothy Andries in an interview in the Pioneer Press: "I thought of writing a one-act play about someone with a disability. I wanted to capture the spirit of a person who has to deal with a disability. So I wrote about obsessive compulsive disorder." The result is* OC Me, *which premiered in September at a benefit sponsored by the OCF of Metropolitan Chicago. What follows are quotes from articles by Eric Zorn and Dorothy Andries, Jessica's thoughts about the play, the creative process and OCD, and quotes from the script and observations from the audience.

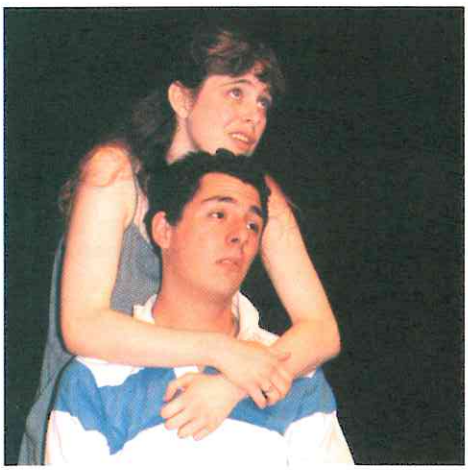
Jessica, who won the VSA Arts 2001 Playwright Discovery Award for *OC Me*, knows her subject well. As she explained it to Eric Zorn for his column in the Chicago Tribune, "My family was on vacation, and I was in the back seat drawing. Then suddenly it felt like something snapped inside and flooded me with fear. I could feel my brain chemistry change." This happened after an attack of strep.

"What if the smell of the paint gets in my lungs? What if I breathe it and get lung cancer? What if my dog licks it off my hands? What if he gets sick? What if he dies? What if he spreads it to my mom? What if I die?"

OCD can be a terrible secret. That explains the title, *OC Me*, which is short for: "Oh see me behind this mask I wear." This is the first line of a poem that Jessica wrote shortly after her OCD started.

Commenting on what the price was to write authentically, Jessica told a reporter: "There is a natural reticence to reveal painful things." But according to the reviews in the Pioneer Press, it paid off. "The result is a remarkable drama, laced with humor and sadness about a teenage girl who suffers from and begins to triumph over OCD."

Besides, writing the play and acting in it, Jessica, who is an award-winning professional storyteller, directed the production. Dorothy Andries in her Pioneer Press article quoted Jessica on her first experience with directing: "The first day, when something came up and everyone looked at me, I almost peeked over my shoulder to see who they were talking to. The actors tell me if a line doesn't ring true. My characters belong to them now. It's very collaborative."



Jessica has captured the isolation OCD imposes. Annie and her boyfriend, played by Sy Barsheshet, discuss what it would be like to kiss without the fear of germs. Despite their fears, they do kiss. But since the main character has OCD, they eventually follow the kiss, after waiting a bit, by rinsing with mouthwash.

Like a Greek chorus, the ensemble dressed in black articulates all of Annie's inners fears: AIDS, germs of all kinds, making choices.

OCD doesn't affect just the person who has it. The whole family becomes involved. Annie's mom played by Farrel Wilson tries to help when Jessica's obsessions take over completely.

There's no neat ending to *OC Me*. Zorn quotes Jessica's thoughts on how a person actually deals with OCD: "You learn to manage it, but those thoughts are always there in the back of your mind. Usually you can be nonchalant, but sometimes you have a recurrence that takes a lot of strength to overcome."

Zorn summed up *OC Me* in his column: "There is more to *OC Me* than the haunting multimedia re-creations of panic. There are jokes. There is a love story."

The September 8 premier of *OC Me* was videotaped. To order a copy of the 90-minute tape, you can send a check or money order to the OC Foundation of Metropolitan Chicago, 2300 Lincoln Park West, Chicago, Il 60614 or email: gsike@aol.com. The cost is $30 for individuals and $50 for professionals (schools, hospitals or medical providers). There is an additional $6.00 charge for shipping and handling.
A portion of the proceeds will be donated to the OCF of Metropolitan Chicago for its programs.

Intensive Treatment Available at Western Psychiatric Institute OCD Center

*Western Psychiatric Institute and Clinic in Pittsburgh, PA has an intensive treatment program at its Center for the Treatment for OCD. Mark Jones, MSW, from the Center, agreed to answer the **NEWSLETTER's** questions about the program.*

Mark Jones, CSW, is the Center's program director.

NEWSLETTER: Can you tell our readers about the Center for Treatment of OCD at Western Psychiatric Institute and Clinic in Pittsburgh? Is it an inpatient or outpatient program?

Western Psychiatric Institute and Clinic (WPIC), a hospital of the University of Pittsburgh Medical Center (UPMC), was recently recognized by US NEWS and World Report as one of the top 10 behavioral health providers in the country. WPIC has an excellent inpatient treatment program; however, the OCD Center at WPIC is an outpatient center providing behavioral therapy (Exposure with Response Prevention) and medication treatment. In cases where a person's symptoms are very severe or do not appear to be responding to weekly outpatient sessions, we refer him/her to our Intensive Outpatient Program (IOP).

The OCD Intensive Outpatient treatment program provides group, individual and family therapy in a concentrated manner, three hours daily, three days per week. We have a morning and an afternoon intensive treatment track. The average length of treatment in the intensive treatment program is 6 to 8 weeks. Clients are assigned a primary therapist who works closely with them on behavioral exposures to the feared obsessions. Clients learn to work on their own as they progress with exposures to acquire the ability to work without the direct support of a therapist, to perform homework exposures and then follow-up with less intensive outpatient treatment.

NEWSLETTER: What is the difference between your inpatient program and your outpatient program?

The inpatient programs provide evaluation, intensive psychotherapy, medication and stabilization. There are specialty inpatient programs at WPIC, but not currently for behavioral treatment of OCD. The outpatient intensive OCD program provides behavioral therapy and medication.

NEWSLETTER: What treatment modalities are used at the Center for Treatment of OCD? Does the program emphasize psychopharmacology or cognitive behavior therapy or a combination of both? Are there other treatments used by the Center's staff?

The primary modalities of treatment at the center are Exposure with Response Prevention and medication. Exposure therapy is often very challenging and medication augmentation leads to greater efficacy of behavioral treatment interventions. Other treatments utilized are cognitive behavioral interventions targeting co-morbid disorders such as depression and other anxiety disorders.

Dr. Robert Hudak is the OCD Program medical director at Western Psych.

NEWSLETTER: Who are the treatment providers at the Center? What are their backgrounds?

The treatment providers are:

Dr. Robert Hudak, M.D., Medical Director, Assistant Professor of Psychiatry at the University of Pittsburgh Medical School, 1992 graduate of Northeastern Ohio College of Medicine, formerly of Case Western Reserve University and Medical Director of the OCD Program at the Cleveland Veterans Administration Medical Center.

Mark Jones, CSW, Program Director, licensed Clinical Social Worker, graduate of the University of Pittsburgh School of Social Work, 1982. Specializing in the treatment of Anxiety Disorders through clinical and research work since 1992.

Lisel Virkler, LSW, program therapist, graduate of the University of Pittsburgh School of Social Work, 2000, with the OCD program since September 1999.

Robin Richardson, MSW, program therapist, graduate of the University of Pittsburgh School of Social Work, 2001, with the OCD program since September 2000.

Julia Lin, M.D., psychiatric resident, 4th year elective rotation through OCD program, functioning in the program as a behavioral therapist.

In addition to the full time staff we utilize interns from the University of Pittsburgh's graduate School of Social Work and from WPIC's doctoral Clinical Psychology Internship Program. All interns have training in ERP and work under the supervision of the center's program director. Currently the following interns are working in the program:

MSW Interns:
Jennifer Lusky, Lynn Farbotnik, Deborah Knight, Sabrina Jackson

Psychology Interns:
Heidi Hamman, Ph.D. candidate
John Ruiz, Ph.D. candidate

Interns allow us to deliver individual treatment to larger numbers of clients. It is very gratifying to see several clinicians annually added to the local and national community of competent exposure therapists.

NEWSLETTER: Do you have a set length for your treatment program?

Most clients require 6 to 8 weeks in the intensive treatment program. We require a minimum of three weeks because the initial week is mostly assessment and education. We have learned that at least two weeks of ERP is needed for treatment to be effective.

NEWSLETTER: What are the improvement rates of your program?

The intensive outpatient program has a mean rate of improvement, as measured on the YBOCS, of 12.67 points, according to outcome data kept over the past year. The average score pre treatment is 28.8 and post treatment, 16.13.

NEWSLETTER: Does the Center offer an intensive behavior therapy program? What differentiates "intensive" behavior therapy from regular CBT?

Program Therapists and interns meet to discuss their cases.

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Western Psych Interview

(contined from page 5)

As we have been discussing, the Center's IOP is an intensive behavioral treatment program. The IOP was created in July 1998 to meet the need for more therapist time to assist clients with their exposures. It is possible for many clients to make progress in ERP without an intensive treatment program, but for many others it is essential that they have the individual attention of their behavioral therapist for several hours weekly. This allows them an opportunity to confront their obsessions and to learn how to habituate to the very high levels of anxiety created when triggering obsessions at or near the top of their hierarchy. The amount of therapist time available to the client is greatly increased in the intensive program. In addition, there is group time, which allows clients to discuss their treatment with each other and to provide support and motivation for their treatment.

NEWSLETTER: What activities and treatments does your OCD program include?

Because we see clients in the IOP for only 9 hours weekly, we spend most of the time doing ERP. This includes preparing clients for behavioral treatment, discussing exposure and response prevention homework and exposure work, both imaginal and in vivo.

NEWSLETTER: Is your OCD program for adults only or do you also treat children and adolescents?

Due to the lack of an intensive treatment program for adolescents in the area, we treat clients from age 16 up. It has been our experience that older adolescents are able to work in an adult milieu.

NEWSLETTER: Can you describe a typical first day in the Center's OCD program?

The initial program day is an assessment, orientation and psycho-education day. The new client meets the program staff and other clients. Then the client is assigned to his/her therapist and they begin getting to know each other. The next order of business is for the therapist to start learning about the client's particular OCD symptoms and then to start to teach the client about behavior therapy.

Then the new client joins the group for an hour of homework review. Present are all other clients in the IOP track, as well as their therapists. The new client listens as others describe their behavioral assignments and group members respond with feedback and support. After the group and a break for coffee, the new client meets with his/her therapist for the remainder of the program day. During this time, a psychiatric evaluation is conducted and then the client's symptoms are quantified using the YBOCS questionnaire.

NEWSLETTER: What is a typical day in your program?

As on the initial day, first on the schedule is the behavioral homework review group, followed by a two-hour individual session with one's therapist. After the assessments and construction of the behavioral hierarchy, the typical day entails behavioral exposures and then sitting with all the feelings generated by the exposure and allowing habituation, while learning to practice response prevention.

The behavioral exposures are of course different for every client. For contamination obsessions, they may be touching things in bathrooms in the building or in the vicinity. The therapist often models the exposure through touching objects prior to asking the client to do so. A visit to a medical facility may be in order. The therapist goes with the client to lend support and to monitor with the client his SUDS reaction (distress scale, 0-100) and to explore for any overt or covert neutralizing, which may need to be built out of the client's safety behaviors.

John Ruiz, psychology intern, and Lisel Virkler, MSW, LSW, are treatment providers at the Center.

Another activity the therapist might do with the client is to create an imaginal exposure, a written script or an audiotape. The therapist works with the client to create an exposure that will help with his particular obsessive fear and then shows the client how to incorporate the script into his exposure and response prevention exercises.

These exposure sessions are approximately two hours long and include debriefing afterwards and formulation of a homework plan. Homework generally repeats the exposures done with the therapist, response prevention and monitoring. Weekly to biweekly medication evaluation appointments with Dr. Hudak are standard. Medications are not required, but are encouraged and most of our clients are prescribed medications.

There are family sessions on some program days.

NEWSLETTER: How many participants can you accommodate in your program?

We see only as many clients as we have therapy staff. Currently we have three full-time clinicians. And, of our interns, three are sufficiently educated in ERP to be seeing clients on their own. Because we have separate morning and afternoon tracks, we can see up to 10 patients daily.

Clients are generally from Western Pennsylvania, or from nearby Ohio. Clients who live too far away to be able to commute to the program may stay at Family House, an independent facility created for families of Medical Center patients to stay nearby for a nominal fee. Clients of the OCD program may reside at Family House if their needs do not exceed the abilities of a non-psychiatric and mostly volunteer staff. Family House has private rooms with a shared lounge and kitchen. Staff of the OCD program are available for psychiatric emergencies 24 hours/day.

NEWSLETTER: Do you have a non-intensive program?

Yes, our outpatient treatment program is active in seeing clients who do not require intensive treatment, or have been treated in the IOP. The same therapists who work in the intensive program see clients in the outpatient program.

NEWSLETTER: What is the program's staff to patient ratio?

The Center for treatment of OC and Anxiety Disorders is committed to providing a one to one ratio of staff to client.

NEWSLETTER: What are the criteria for admitting a patient into your program?

We use the following admitting criteria: presence of OCD or OC spectrum disorder; willingness to participate in ERP; willingness to spend a minimum of three weeks, but usually 6-8 weeks; ability to tolerate increased anxiety from exposure work without experiencing a symptom increase in other illnesses.

NEWSLETTER: What factors should someone consider when s/he is trying to determine if the Center's program is appropriate for him/her?

The questions a person should ask himself are: Are you aware of what exposure therapy entails and are you motivated to work with a therapist on your disorder utilizing this modality? Do you have any other psychiatric illness that would preclude this behavioral approach at this time?

NEWSLETTER: Are your programs covered by private insurance?

Yes, most insurance plans cover our intensive and less intensive programs. We contact insurance companies requiring pre-authorization and maintain contact through treatment to ensure continued authorizations are obtained.

NEWSLETTER: Do you do any mediation trials or research projects at the Center that would allow a participant to be treated for free?

WPIC does undertake research projects, but

Western Psych Interview

at this time there are no treatment studies available for OCD or OC spectrum disorders.

NEWSLETTER: Do you have any funding sources that allow you to treat an eligible patient for free? How would someone apply for these programs?

The only funding source allowing clients to be treated without insurance is through Allegheny County's mental health program. To qualify for this, the individual must be a resident of Allegheny County.

NEWSLETTER: Are any of your staff members involved in research programs? What kind of research is being done at the Center?

Staff from the OCD program is involved in research, but not directly through the OCD program. Clients at WPIC are routinely made aware of opportunities to participate in research studies, but it does not affect their participation in the OCD program, which is not a research program. Recently, some clients from the program were participants in a neuro-imaging study (Dr. Cameron Carter and others), utilizing fMRI brain scans to research the involvement of the anterior cingulate cortex in OCD.

NEWSLETTER: Do you have any programs for individuals who are treatment refractory?

Many of our clients come to the program with that label and do well. We do not have any program that specifically is designed for a treatment refractory population.

NEWSLETTER: How is the situation handled if a patient has not improved sufficiently at the end of the program? Can he stay on? Do you have alternative treatment protocols?

The program is two months in length and occasionally clients stay longer because they have not improved enough to move on to the less intensive outpatient treatment program. Other than the less intensive outpatient program, there are no other programs at WPIC.

NEWSLETTER: What alternative does a patient have if he/she hasn't achieved a satisfactory remission of symptoms at the end of your program?

Because we are an intensive outpatient program and see clients three days a week for a total of 9 hours, more intensive programs are available. We are regularly in contact with other OCD treatment centers and have on two occasions over the past three years made referrals to inpatient or residential programs, which may prove more useful for the client.

NEWSLETTER: Since OCD is a chronic illness, relapse is a big issue. How does you program deal with this problem?

Therapists, especially for clients who may not have clinicians in their area with whom they can continue behavioral treatment, routinely address relapse prevention. Our primary goal is to assist clients in achieving significant improvement in their symptoms and to be able to continue the behavioral work with a therapist in a less intensive treatment program.

NEWSLETTER: What kinds of follow-up programs does the OCD Center offer?

The Center provides follow-up in whatever form is appropriate, from weekly outpatient individual therapy and/or medication review to group treatment. There is a specialty group for people with hoarding problems in the outpatient program, as well as OCD groups for individuals who are in need of education and support, but not able to utilize behavioral interventions due to other severe and chronic psychiatric problems.

One of our recent post-doctoral fellows, Andrea Schwartz, Ph.D., has created a GOAL group in the suburban North Hills section of Pittsburgh and, in conjunction with current and former therapists from the center, works with clients in a therapy/support group twice monthly. The GOAL group does not require prior or current behavioral treatment, but such experience is highly recommended.

NEWSLETTER: Does your program accept people who have multiple diagnoses? Can someone be included in your program if they have substance abuse problems or a co-morbid condition?

There are no exclusions based on having problems other than OCD. Sometimes the presence of other psychiatric problems may interfere with intensive behavioral treatment of OCD and may necessitate treatment for these other problems first. The OCD program has treated individuals with schizophrenia and bipolar disorders, as well as the very common multiple diagnostic presentation of depression and other anxiety disorders with OCD. Sometimes individuals are too depressed to benefit from behavioral treatment of their OCD, and do better after the depression has begun to lift. Sometimes depression cannot be treated until the OCD has begun to improve, and so it makes sense to treat both disorders together.

Anxiety Disorders including Phobias, Social Anxiety, Generalized Anxiety, and Panic Disorder are treated at the OCD Center. Cognitive behavioral therapy, often combined with medication treatment, is also the most effective therapy for these Anxiety Disorders and can be treated through an outpatient or intensive outpatient protocol at the Center. Every individual is closely evaluated and treated according to his/her needs.

NEWSLETTER: If someone is in an emergency state, can they be admitted to the Center's program?

The acute nature of an individual's illness is balanced with the necessity of providing treatment on a first come, first served basis. The intensive program cannot admit more patients than there are staff to treat adequately. Emergency cases often require inpatient admission for stabilization prior to intensive outpatient treatment. Patients are often admitted to outpatient treatment to begin therapy prior to starting with the intensive program.

NEWSLETTER: Does the Center have support groups in which patients can participate after completing the program?

Yes. Support groups for people with OCD and for their families are available monthly at the Center for Treatment of OCD. No registration or fee is required. Current or former treatment through the CTOCD is not required to attend the support groups. At the OCD program there is the OCD Support Group, a group for adults with OCD, providing a forum to share information and support, and the OCD Family Support Group, a group for families and significant others of people with OCD.

We are also affiliated with a GOAL group in the North Hills area of Pittsburgh, facilitated by current and former treatment staff from the OCD program. The GOAL group allows people to work on behavioral treatment goals, in conjunction with outpatient treatment at the OCD program, as follow-up, or prior to formal treatment.

NEWSLETTER: Does the Center involve patients' family members and significant others in the treatment program? Are there informational meetings for family members? Are they involved in a patient's therapy program?

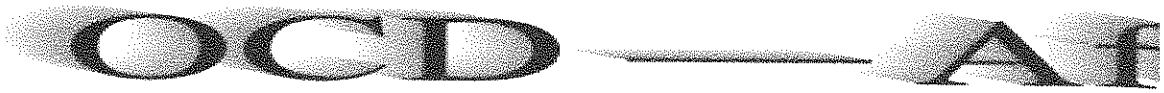
Yes. As you know, OCD creates significant disruption among families and we strive to address this through meetings with both the client and the family on a regular basis. It is important that significant family members understand the disorder and behavioral treatment. This allows the client to have support as he struggles with the distress of the exposure and with response prevention assignments. We have included families in the treatment day, when indicated, allowing them to obtain a first hand understanding of the process of behavioral treatment.

NEWSLETTER: If someone is interested in the Center's program, where can s/he get more information and who should s/he call?

They may call me @ 412 624-4466, or send email to me at jonesmr@msx.upmc.edu.

We have a newsletter which I'll send with articles by both staff and clients which is useful in getting a better understanding of the illness, the treatment and the program.

Deadline for 9th OCF Conference Presentations is Jan. 15, 2002.
Call Jeannette Cole at 203.315.2190 for more information.



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Anthrax, but I sure am concerned about bathroom germs!" Interestingly, this illustrates how OCD doesn't involve global impairments in judgment or other cognitive processes. Just like people without OCD, those with OCD find some situations extremely threatening and others not. Moreover, uncertainty is tolerable in some situations, but not in others.

New Obsessions?

If the stress associated with the recent events can exacerbate existing OCD symptoms, can it lead to the development of new obsessions and compulsions? We suggest that this is a possibility. A potential problem is the threat of bio-terrorism, which is something that people with OCD contamination fears already have experience with! Contamination obsessions usually involve excessive fears of germs; and people with this presentation of OCD respond fearfully when the actual threat of harm is quite low. This is the exact situation we are currently facing with scares of Anthrax and other biological weapons. News reports about people panicking over spilled sugar, flour or other ground white (yet safe) substances mimics the behavior (and likely the thinking) of people with OCD contamination fears. Anthrax is extraordinarily uncommon, yet the consequences of contamination may be severe. It remains to be seen whether Anthrax, like AIDS, will become a common obsessional fear in the future.

Conclusions

In executing high profile attacks and bombarding the media with propaganda, terrorists and terrorism have struck at the heart of American fears and uncertainty. For a long time we felt relatively secure in our nation, despite the inevitable looming threat of these kinds of attacks. Now, we must adjust to a state of alertness (as much of the world has done before us) and assume that anything is possible. As we have discussed, this can present a challenge for people vulnerable to anxiety and worry, and who have problems coping with anxiety (such as compulsive rituals or avoidance). In the coming months, we will learn more about the psychological impact of these events on people with and without pre-existing anxiety problems – research is already underway. Luckily, there are treatments that are generally helpful in reducing anxiety symptoms, and I am confident that more specialized interventions will be developed and tested to help us in dealing with the aftermath of September 11, 2001.

Terrorist Attacks on OCD

Jerome Bubrick, Ph.D., Fugen Neziroglu, Ph.D., and Jose A. Yaryura-Tobias, M.D., Bio-Behavioral Institute, Great Neck, New York

The events that transpired on September 11, 2001 have changed Americans' outlook on the world. The days of arriving at the airport 30 minutes before departure, checking bags curbside, walking nonchalantly to the gate with only an e-ticket are over. The act of mindlessly rattling off a few yes's and no's to those silly questions asked by airline agents about the "safety" of your bags is history. The twin towers no longer define the skyline of New York City. Ironically, we now know that the Pentagon, the heart of the nation's defense system, is indefensible.

Certainly, everyone in the country has been affected in some way by the terrorist attacks; but individual responses appear to be indicative of pre-terror anxiety levels. For many people, the attacks signaled the need to be more cautious in everyday life. But the attacks have not robbed them of the ability to function. Some, including those who had higher levels of pre-terror anxiety, are very concerned with security. For example, many people are avoiding large crowds and not eating out at restaurants. Others are not going on trips planned months ago, are missing famous Broadway shows, are avoiding the subways and tall buildings, and are spending weekends at home. Others are having recurring nightmares and flashbacks as a result of watching the planes slam into the buildings on live television. Everyone seems to be glued to the television, hoping to hear the President say everything will be all over and back to "normal" soon.

Others have been taking even more active measures in order to reduce their anxieties about what may come next. Many military surplus stores in the city are out of stock of gas masks and have 3-month waitlists for back-orders. Scores of people have been hoarding Cipro (an antibiotic used to treat Anthrax), and others are afraid to open their mail.

Although people feel these behaviors are justified, they are simply avoidant behaviors and help only to temporarily reduce anxieties or fears of the unknown. In a sense, for people with high levels of pre-terror anxiety, the terrorists have increased their anxieties to panic, post-traumatic stress, hoarding and a potpourri of avoidant behaviors.

If this has been the response of some of the American people, one may assume that people with OCD must be responding with even more extreme measures. However, keep in mind that old expression about the danger of assuming things. Just as there is variation in responses in people without OCD, there too are various responses among those with OCD.

Because we are on Long Island and only 30 minutes from Manhattan, our assumption was that our patients would be terrified and there would be an increase in symptoms. We immediately set up free support groups twice a week. For the first 5 weeks we did not get one single person to attend and only last week a few people started trickling in. We decided to poll our staff at Bio-Behavioral Institute to see how their patients with OCD are responding. What is going on? Is there an increase in phone calls, more emergency visits, more heightened anxiety, more obsessions and compulsions, and/or any other increase in behaviors indicative of the effects of September 11th? We asked the staff to compare the OCD patients' responses to others in general. All together we treat hundreds of patients with OCD and interestingly our observations were very similar. The majority of our OCD patients are not responding with any more anxiety or concern than the rest of us. Perhaps the only difference is that they question or doubt whether their level of anxiety is appropriate or similar to others in the general public. This is not surprising because doubting is one very prominent symptom of OCD; but the reality is that they are quite rational and continue on their activities just like the rest of us. Some of us are doing better with anticipatory anxiety and others of us are more avoidant. We are all different but patients with OCD do not seem to be that much more different than the rest of us.

Obviously those who had friends, family, or acquaintances directly affected by the attacks, have had significant symptom increases. For these people, because of their heightened states of anxiety, there has been an increase in the amount of compulsive behaviors to reduce the effects of the anxiety. There has been more reassurance seeking, especially with family members and loved ones. Some people have become very fearful that there will be more attacks. This has resulted in fear that their loved ones, especially those who work or live in New York City, are in harm's way.

There is also anticipatory anxiety about whether or not their symptoms will worsen over time with sustained levels of heightened anxiety. People are afraid to get comfortable because of the fears that another attack could happen at any time, thus they cannot habituate to their current levels of anxiety. As these anxieties linger, the compulsive acts become more tempting to engage in. But as tempting as they seem, they only give a perceived sense of security.

Only time will tell if another attack is on the horizon, but as of now it appears that the attacks of September 11th have caused a variety of responses from the American people, OCD or not.

The New Status Quo: Living with Uncertainty

James Claiborn, Ph.D., Manchester Counseling Services, Manchester, New Hampshire

I work with people with a range of problems. Many of them have OCD, of course, but often they have other problems as well or additional disorders. In the first several days after the horrible events of September 11th, almost everyone who came into my office started out with a remark about how, in light of what was going on, his/her problems seemed trivial. Most of them, however, seemed ready to continue to work on the problems that caused them to seek therapy in the first place.

I tried to think what I would expect to happen to people with OCD as a result of this type of event. I think about it in terms of uncertainty. Most of us go to work each day and assume we won't face danger. The building will still be standing at the end of the day. Most of us get on airplanes from time to time. Almost everyone who flies probably has some thoughts about planes crashing but we don't really expect it to happen to us.

In some ways, all of us live with the uncertainty about what each day will bring; but most people don't spend much of their time trying to figure it out. They operate with an expectation that things will usually work out although they cannot be absolutely certain. This is where the people with OCD differ.

One of the ways I find useful to conceptualize OCD is to think of it as intolerance of uncertainty in some areas of a person's life. Obsessions are upsetting because they arouse the uncertainty. What if I go crazy and kill my loved ones? What if

er the Attacks

I am exposed to dangerous germs and get sick or spread them to loved ones? What if my wishing my mother dead causes her to die? What if I am really gay? The examples could go on and on but the underlying theme is the same.

The response to this arousal of uncertainty is to try to obtain certainty. The washing, checking, repeating and other forms of compulsion are designed to get to the point where the individual knows for certain that things are okay.

In a few weeks I will get on an airplane and fly to another city. I will have some thoughts about hijackings and death in a plane crash. I will probably reassure myself that it is safe in the sense that I don't think I am in immediate danger. Am I going to be 100% sure? No. I hear about threats like Anthrax being spread by terrorists. Do I believe it could happen? Yes. Do I worry about it or take special precautions to try to be 100% sure it is safe? No, but I don't have OCD.

I learned that the city I live in had an Anthrax outbreak many years ago. It seems workers in a mill were exposed because of some animal hair used in making cloth. Most, who were exposed, died. The buildings were torn down and the area converted into a family park. I have been suggesting we could have an OCD picnic there. Am I 100% sure that is safe? No. Am I willing to tolerate that uncertainty? Yes.

As I see it, the effects of the events of September 11 are the same for everyone living in the US. We had assumed we were safe. We had expectations that everything was okay. When I woke up on the 12th, I wondered if it had all been a bad dream. It changes my assumptions about safety. I liked feeling safe. I know that I cannot feel safe the way I used to. I have to accept the fact that the feeling of safety is changed and no amount of checking, praying or other rituals will change it back. Since dealing with OCD is about learning to live with uncertainty, maybe my patients with OCD will have a head start. What has really happened is that the areas of uncertainty we have to live with have been expanded.

Real Horrific Events and OCD

William M. Gordon, Ph.D. Private Practice Montclair, NJ

From an overlook in Montclair, NJ, twelve miles due west of Manhattan, people watched The World Trade Center burn and crumble. The growing crowd was silent. All knew that family members and neighbors worked in those towers and the surrounding area. This was no distant, abstract event; this was an ongoing personal horror. The sense of danger and uncertainty was real, and at times, overwhelming. People first responded by trying to check on the safety of their families.

Then came the emotional mess: waves of grief, insecurity, and rage – all jumbled together. People talked about it endlessly, read the newspapers, and watched television. They volunteered to help by donating their money, services, and blood. A new aura of generosity and civility appeared in everyday life. Drivers waited their turn, the honking stopped, and petty quarrels were put aside. People in general went out of their way to get along and be nice. Ultimately everyone went back to work.

As a psychologist working primarily with people who have OCD, I wondered how my patients would respond to the tragedy. For after all, here was a real crisis loaded with tangible danger, high anxiety, and uncertainty – the very ingredients that feed OCD. How then did they respond? In a nutshell, they responded the way everyone else did. They got upset, talked about it, and then went about their business.

Several patients did incorporate parts of the tragedy into pre-existing obsessive patterns. One patient, who has "a need to know" irrelevant information, was distressed that he could not understand someone's accent who was being interviewed on TV. Another patient, while watching television, obsessed about possibly having seen a survivor in the rubble who the rescuers overlooked. Both of these patients wanted to engage in checking behavior to resolve the doubt.

A different individual, suffering from scrupulosity, was genuinely horrified by the destruction but then started thinking: What if I were to say "ha, ha, ha"? What if I said, "Too bad more people didn't die"? I must be evil to have thoughts like that! No...he's not evil, but he does have OCD. Seeing the similarity between these blasphemous thoughts and previous thoughts about sex helped to put things in perspective.

As already mentioned, these patients used the recent tragedy as fodder for pre-existing obsessive patterns; they did not develop new symptoms in response to the attack. The overall severity of their OCD did not increase; for some, their symptomatology actually decreased. In general, they responded effectively and appropriately to a real tragedy.

I am not suggesting here that OCD in any way immunizes one against experiencing psychic trauma. Rather, I am pointing out the resilience and competence that people with OCD demonstrate in actual crisis. When faced with real problems, people with OCD cope. They might play with the situation obsessively, but they handle it. They don't fall apart.

This ability to confront real problems is in marked contrast with their inability to cope with certain hypothetical, imaginary ones. Take issues surrounding sickness and sin as two examples of this difference in coping ability. People with OCD might worry endlessly about getting sick from virulent phantom germs lurking in the most fantastic places. No amount of reassurance or checking dispels the fear and doubt. Yet these same people can handle an actual diagnosis of cancer. The nearly impossible chance of catching AIDS from a doorknob can lead to psychic paralysis; the actual diagnosis of serious disease leads to normal coping.

Scrupulosity is another area which illustrates this same difference in coping. Despite being preoccupied with moral rectitude, sufferers from scrupulosity do make mistakes and commit infractions. They drive over the speed limit, cheat on their taxes, tell white lies, and say mean things – just like everyone else occasionally might do. Surprisingly, their guilt over these actions is generally minimal. Where they often do experience profound guilt is in response to "immoral" thoughts, urges, or omissions that supposedly reflect poor character. Thus, the actual misbehavior leads to less guilt than the possibility of having a murky urge to do something bad in the future.

We see then an interesting contrast in how people with OCD deal with issues involving morality and health. They handle real events well but imaginary ones poorly. They can cope with a painful, difficult present reality; they cannot cope with a contrived, hypothetical future. They engage in effective problem solving, if and only if, there is a real problem. In this respect, people with OCD are no different from others. For no one can solve a problem "that's not there." Where the obsessive person fails is in repeatedly trying to solve imaginary problems rather than letting them go.

This distinction between coping with reality and coping with fantasy can help an OCD sufferer in several ways. First, it's good for one's confidence to realize that in times of true crisis one's natural coping mechanism kicks in and gets you through it. Second, if you experience prolonged anxiety, doubt, and indecision, it suggests that you are facing an obsessive fear. In real crises, you react quickly and effectively. And finally, if that one in a million chance of a horrific fear coming true actually does happen, you will probably handle it as well as anyone and a lot better than you imagined.

Aftershocks of September 11th Events

Jonathan Grayson, Ph.D. The Anxiety and Agoraphobia Treatment Center, Bala Cynwyd, PA

Since the terrorist attacks of September 11th, and the subsequent bioterrorism via Anthrax, the whole nation has been in shock, a kind of post traumatic stress, the effects of which depend both upon the individual and his/her closeness to the events. Many people have asked me: how is this affecting people suffering from OCD? Are they worse? More upset? Are they having new obsessions? This is the wrong question. I'm sure there will be some people suffering from OCD, whose contamination issues will now incorporate the mail. This is not unlike the shift we saw in contamination fears once AIDs became a public concern. Prior to AIDs, one couldn't predict what disease an individual might fear, now most contamination fears focus on AIDs. However, this is merely a shift in symptom focus. Some of our clients are reporting an increase in symptoms as the result of stress, because for all people, problems tend to increase as the result of stress. Others actually report a lessening of symptoms, that the events have helped them to put their OC concerns in perspective.

For me, the connection between OCD and our "new world" has to do with those not suffering from OCD. I have seen numerous people, friends, friends of friends responding to current events in an OC-like way. First of all, everyone is thinking about the disaster daily; unpleasant thoughts intrude into whatever they are doing. Are these obsessions? They are not, but for only one reason – we don't try to make the thoughts go away. We accept our inability to avoid their intrusion. To

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From the Foundation

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about our personal experiences of frustration with it. We felt the same. No surprise.

But, then, simultaneously, we both started talking, one picking up when the other stopped for a breathe, about how it could be used to help people with OCD. (My friend doesn't have OCD. She's just a really ethical person.) I told her that one of the mothers who is on our Education Task Force, Tamra Wulff, had directed me to an interesting case last spring, *Humphrey v. Memorial Hospitals Association.*

The plaintiff, Ms. Humphrey was a medical transcriptionist who was fired because she had a hard time getting to her job on time and sometimes she couldn't get there at all. She had OCD and she had to wash her hair until it felt right. Her employer made some accommodations in the form of flexible work hours. Ms. Humphrey's OCD was so acute though that the flexible working routine didn't help. She went back and asked to work at home. In true "Catch 22" fashion, the hospital told her she couldn't work at home because she was on probation for chronic lateness and unscheduled absences. Eventually she was fired because she couldn't get to work on time. This was in 1995.

Subsequently, she brought suit against her employer under the Americans with Disabilities Act. This spring, the U.S. Court of Appeals for the Ninth Circuit, a very, very influential federal court, ruled in her favor, saying that her employer should have offered her a leave of absence when the flexible work schedule failed. That's the good news.

The bad news is that the employer has appealed this ruling to the U.S. Supreme Court and in the beginning of October the Supreme Court, without saying it would hear the case, asked the solicitor general of the United States to file a brief with the Supreme Court expressing his views on the situation. If I were a betting woman, I would put money on the solicitor general taking the employer's side. Before, becoming solicitor general this year, he argued cases for insurance companies and HMOs.

This was grist for our mill. What could we do? File an amicus brief? That's when an interested group that can show an important stake in a case is allowed to argue its position even though it is not a party to a case. Not practical. The Foundation already has a pamphlet on the Americans with Disability and the Rehabilitation Act of 1973. Edward Matisik, JD, a Washington attorney and disability advocate, wrote it in 1996. And, he is presently in the midst of updating the pamphlet. He's exploring how the courts have been applying the ADA and the Rehabilitation Act of 1973 to people with mental illness. No need for us to do the same thing.

Then, we had an idea. We could pull together a "How To" booklet. It would be a supplement to the work Ed has done and is doing. We would develop possible scenarios, situations that someone with OCD might run into in the workplace; and then we would suggest, based on the laws and the cases, possible solutions and types of accommodations. We could include information on when and how to file a claim with the EEOC or how to find a lawyer who handles these types of cases. We could ask members to write us about their work experiences and we could draw our case studies based on real situations. We could get people practicing in the field to be on a referral list and cajole them into writing NEWSLETTER articles on important cases and rulings. We could research what kinds of documentation you need to establish the right to an accommodation and find out what your treatment professional has to say in his/her report to establish eligibility.

That was a week ago. Since then I've found the website for National Council on Disability with a copy of their report on the ADA, "Promises to Keep: A Decade of Federal Enforcement of the Americans with Disabilities Act." Guess what the bottom line is as far as mental disabilities are concerned: We've got a long, long way to go. We also discovered the web page for the Boston University Center for Psychiatric Rehabilitation (Debbi Nicolellis who has done Social Security seminars at the Annual Conference is at this center.) It has pages and pages on mental illness and work, disclosing your disability to an employer, possible accommodations. We downloaded everything.

Everything is very preliminary right now. We're mailing cases back and forth. And, we need your help. We need you to share your experiences with us. The bad ones and the goods ones. When I was at Yale as an inpatient in an SSRI trial, I got a phone call from my employer telling me that he was very sorry, but the firm was removing me from the letterhead. Unfortunately, that was before they passed the ADA. Then, there was nothing I could do. Now there is. So, send us your stories, your questions. Tell us about the accommodations you were able to negotiate and the ones you weren't. Tell us what happened when you told your employer you had OCD or why you didn't. We need to pool our experiences and use them to help each other get a chance to do the work we can do.

Ciao!

Patricia Perkins-Doyle
Executive Director

Letter from Michael Jenike

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be sure that the finest are funded. Last year we were only able to fund three projects out of a large group of worthy applications. The only thing holding us back from progress in these disorders is the lack of research funding. We have the skilled researchers submitting projects for funding already.

Unfortunately, these talented people will look elsewhere and work on other disorders if we do not rise to the challenge. Many organizations have become major funders of high quality research. As noted in the past, organizations such as NARSAD, Tourette Syndrome Association, and the Alzheimer's Association raise many hundreds of thousands of dollars apiece to support research into their respective areas of interest. Many of the world's best researchers decide to study particular disorders based on the availability of funds. If we are going to push OCD research to the forefront, we will need to be able to offer more research dollars to investigators.

I know that this year in particular there are many worthy causes asking for donations, but the suffering that OCD patients endure is second to none. We need your help to assist us in finding the causes of OCD and in developing new and more effective treatments. I sincerely thank you for any financial help you can offer.

Sincerely,

Michael A. Jenike, MD
Chairman, OCF Scientific Advisory Board
Professor of Psychiatry
Harvard Medical School

Call for Conference Presentations

The 9th Annual OCFoundation Conference is scheduled for August 9-11, 2002 in Philadelphia, PA. Anyone who is interested in putting on a seminar, workshop or presentation must submit his/her presentation proposal to the Conference Committee by January 15, 2002.

Again this year, the Conference will have three tracks focusing on three separate interest groups: people with OCD, children, adolescents and adult children with OCD and their families, and OCD treatment providers. Conference planners are looking for presentations addressed to these three groups. In the 2001 evaluations, conference attendees stated that they would like to see presentations on recent research, treatment options, "how-to" behavior therapy demonstrations, seminars for mental health professionals, presentations by parents for parents, legal rights, securing insurance coverage for treatment, hoarding, GAD, SAD and the Spectrum Disorders and options for treatment-resistant OCD.

For an official proposal form, call Jeannette Cole, deputy director of the OCF at 203.315.2190. Only submissions on the official form will be considered.

Research Digest

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

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

Abstractor's Comment:

Cognitive behavior therapy (CBT), employing exposure and ritual prevention, and drug therapy, with serotonin reuptake inhibitors (SRIs), are the current treatment choices for OCD. While both are recommended and worthwhile, they are usually partially effective. Their combination is often recommended with the hope that the combination will be superior to either treatment alone. Past research has yielded conflicting results although the weight of evidence favors combined therapy over either therapy alone. At this point, it is more the extent of increased effectiveness that is being studied as well as ways to make CBT more available. In light of the importance of this question we are summarizing results from three recent studies. Additionally we are presenting study results on other aspects of CBT. Other abbreviations you will see in the reviews are: clinical global impression of improvement (CGI-I); clomipramine (Anafranil) (CMI), placebo (PL), and Yale-Brown Obsessive Compulsive Scale (Y-BOCS).

Combined effects of pharmacotherapy and cognitive-behavior therapy in treating OCD

Presented at the American Psychiatric Association Annual Meeting, Chicago, IL, May 13-18, 2000, D.M. Direnfeld and M.T. Pato

Behavior therapy, using exposure and ritual prevention, was added to SRI treatment of 23 individuals with OCD in an effort to determine if combination treatment was superior to that of medication alone. After an adequate trial of SRI, there had been a 15% reduction in Y-BOCS scores and four individuals (17%) had responded with at least a 25% reduction. When exposure and ritual prevention were added, an additional 20% reduction in the Y-BOCS scores was obtained and 14 more individuals (61%) now had at least a 25% Y-BOCS scale reduction. Also of interest, behavior therapy was provided in a group setting, a more cost-effective approach than traditional individual therapy.

The effect of fluvoxamine and behavior therapy on children and adolescents with obsessive-compulsive disorder

Journal of Child and Adolescent Psychopharmacology, 10:295-306, 2000, F. Neziroglu, J.A. Yaryura-Tobias, J. Walz and D. McKay

In this study 10 children/adolescents who had not previously responded to behavior therapy were randomly assigned to two groups: fluvoxamine (Luvox) alone or fluvoxamine with CBT. Patients receiving the combination treatment showed significantly more improvement than those only on medication. At two-year follow-up, all patients continued to improve, with those in the combined approach improving more than those in the medication-alone group. Researchers propose that medication enabled these children/adolescents to perform CBT successfully, where prior to fluvoxamine treatment, they had been unable to engage in CBT adequately. It should be noted that there was significant improvement with medication alone in patients who had not responded to CBT, but the addition of CBT further reduced the OCD symptoms.

Cognitive behavior therapy and pharmacotherapy for obsessive-compulsive disorder: the NIMH-sponsored collaborative study

In: Goodman WK et al (eds), Obsessive-Compulsive Disorders: Contemporary Issues in Treatment, Lawrence Erlbaum: Mahway, NJ, 501-530, 2000, M.J. Kozak, M.R. Liebowitz and E.B. Foa

Researchers present preliminary results from an ongoing multi-site study comparing CMI, CBT, their combination, and pill PL. CBT and CBT + CMI appear superior to CMI and all three surpassed PL in the analysis of patients who completed the 12 week study. When the entire population of patients (including those who dropped out over the 12 weeks) was considered, the Y-BOCS reductions were: PL 1.3; CMI 7.4; CBT 8.6; and CBT + CMI 11.9. Interestingly, using CGI-I ratings of "much" or "very much improved," the percents of patients achieving these good outcomes were somewhat different: PL 5%; CMI 39%; CBT 61%; and CBT + CMI 46%. Taken together, these results do not indicate that combination therapy is better than either individual treatment. Of interest, after 12 weeks of treatment the medication alone group had a higher dosage level than the medication plus behavior therapy group, suggesting that the addition of CBT lowered the required CMI dosage. Because of small sample size the findings in this study are not definitive at this time.

Behavior therapy versus clomipramine in the treatment of obsessive-compulsive disorder in children and adolescents

Journal of the American Academy of Child and Adolescent Psychiatry, 37:1022-1029, 1998, E. De Haan, K.A.L. Hoogduin, J.K. Buitelaar and G.P.J. Keijsers

This study compared the effectiveness of CBT, employing exposure and ritual prevention, and of medication, using CMI, in 22 children and adolescents with OCD. Significant improvement was obtained with both treatments, although patients receiving CBT had twice the reduction in Y-BOCS scores as patients receiving CMI (12.4 vs. 6.2, $p < .047$). Treatment of five of the non-responders (mean Y-BOCS reduction at 12 weeks = 3.6; two receiving CBT and three receiving CMI) was continued with a combination of CBT and CMI. A substantial improvement in OCD symptoms occurred for all five individuals (total Y-BOCS reduction 11.6). Researchers state they do not know whether it was the extended period of treatment (both for CBT and drug therapy) or the combination treatment that accounted for this improvement. The superiority of the combination of behavior therapy and drug therapy cannot be answered by this study in part because of the small sample size and its uncontrolled design, but results support the combined treatment approach for those not responding to either treatment alone.

Case study: bibliotherapy and extinction treatment of obsessive-compulsive disorder in a 5-year-old boy

Journal of the American Academy of Child and Adolescent Psychiatry, 40:111-1114, 2001, D.F. Tolin

Little is written on the treatment of OCD in very young children. This case report is noteworthy in that CBT was successful in a 5-year old child and in that an OCD storybook was creatively used in the treatment. The boy's parents repeatedly read "Blink, Blink, Clop, Clop: Why Do We Do Things We Can't Stop? An OCD Storybook" to him. The book encourages children to ignore the "OC Flea" and even make fun of him. The child was able to relate the story to his obsession with germs and need to wash. He also enjoyed thinking up new insulting names for "OC Flea" and ways to squash "OC Flea." Additionally, the teacher and parents were instructed not to provide reassurance in response to repeated questions about cleanliness and germs, instead reminding him that he probably already knew the answers to his questions. Using these strategies, extinction of compulsive reassurance-seeking and bibliotherapy with an age-appropriate book on OCD, cognitive-behavior therapy was an effective treatment that persisted at 1 and 3 month follow-ups.

Abstractor's Comment:

It is very unusual to see patients with OCD have a complete remission (Y-BOCS=0). Almost always, this dramatic, unusual and most welcome response occurs in children which is another reason that early identification and treatment in children is so important. In my experience, no more than 25% of children achieve Y-BOCS scores less than 2, but that is a much higher rate than found in older patients.

Cognitive-behavior therapy of obsessive-compulsive disorder in private practice: an effectiveness study

Journal of Anxiety Disorders, 15:277-285, 2001, R. Warren and J.C. Thomas

This study addresses the question, can CBT in private practice be as effective as the CBT delivered in research settings? Nineteen of 26 patients (73%) completed treatment, 84% were treatment responders with an average Y-BOCS reduction of 11.4. Patients, treatment, and outcome were compared to randomized controlled trials and more similarities than differences were found. Overall, 19 earlier studies reported a 46% reduction in Y-BOCS scores while the authors' clinical practice patients achieved a 48% reduction. The authors conclude that CBT can be as effectively delivered in routine clinical practice.

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FUNDRAISER FOR OCF GENETICS CONSORTIUM

"Imagine being told that your children have inherited a neurobiological disorder that is unpredictable in course and has no cure." This is the opening line in the letter Nancy and Robert Guenther of Evanston, Illinois sent to friends and family, inviting them to a fundraising dessert and talk on Sunday afternoon, October 14.

The talk was by Dr. David Pauls, Professor of Psychiatry (genetics), Harvard Medical School and director of the Unit of Psychiatric and Neurobehavioral Genetics at Massachusetts General Hospital. Dr. Pauls, who is also a member of the OCFoundation's Scientific Advisory Board and is putting the OCF Genetics Consortium together, spoke about his research which focuses on the genetics of Obsessive Compulsive Disorder and Tourette's Syndrome. After the basic talk and slide show, Dr. Pauls took questions for about 45 minutes from the audience.

This fundraiser has raised more than $7,000 for the OCFoundation's Genetics Consortium. Asked what inspired her to put on a fundraiser, Nancy Guenther explained that her family was her inspiration. Over the past 20 months, the Guenthers had learned that all three of their children had symptoms of Obsessive Compulsive Disorder, Tourette's Syndrome and other related disorders. After her children were diagnosed with OCD, Nancy started doing research on the condition.That's when she realized that she too had been suffering from OCD for most of her life.

Nancy introduced herself to Dr. Pauls at the OCF Annual Conference in Chicago in 2000. She felt that he would be interested in her children because of the fact that all three of them had OCD and other related disorders. At this year's Conference in Denver, she talked with him again about her family being involved in the Johns Hopkins University studies. "He was so very compassionate and so interested," said Nancy, "that I decided to ask him speak at our fundraiser."

This was no spur of the moment decision. Nancy had started thinking about doing her fundraiser shortly after her children were diagnosed. When she read about the fundraiser given by Joy and Douglas Kant in the OCD NEWSLETTER, she decided it was time to schedule the one she had been planning. Shortly after reading the article, Nancy contacted Joy, looking for advice. One of the many things Joy told her that turned out to be absolutely fundamental to the success of such an undertaking was to start immediately to make a list of people to invite. Joy told her to include everyone: family, friends, neighbors, business associates, and colleagues. Joy also gave her copies of the letter and invitations she had used for her gathering.

Nancy got help from her friends and members of the OCF Metropolitan Chicago affiliate. One of her friends, a caterer, made the desserts for the cost of the ingredients. Another friend created fall centerpieces for the tables. Ann Coulter from the Chicago affiliate helped her with all the details, including picking a video to show her guests that would explain to them what OCD was like for someone who had it. One of her friends even played the piano while people helped themselves to desserts and made themselves comfortable.

Asked what the hardest part of putting the fundraiser on, Nancy responded: "It takes a great deal of time. And, with three kids with various problems, that is something I don't have. There are a lot of details. My OCD really came in handy because you've got to check everything to ensure that the party is successful."

"The biggest satisfaction, aside from being able to raise money for something that we feel is so important, was being able to educate my friends and family about OCD," said Nancy. "People learned a great deal about OCD." "Another amazing thing," Nancy explained, " was the generosity of people, who were not personally affected by OCD. Not only did friends and family give generously, but many who couldn't come took the time to write notes expressing their good wishes. It was an amazing outpouring for a really important project."

Research Digest

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Danger Ideation Reduction Therapy (DIRT) for treatment-resistant compulsive washing

Behaviour Research and Therapy, 39:897-912, 2001, A. Krochmalik, M.K. Jones and R.G. Menzies

Danger Ideation Reduction Therapy (DIRT) is a cognitive therapy that does not include formal exposure and ritual prevention. Instead DIRT seeks to change beliefs about contamination by providing corrective information, attention training with breathing exercises, cognitive restructuring, expert testimony, microbiological experiments and a probability of catastrophe task. Five individuals, whose OCD had failed to respond to medication or behavior therapy and who had poor insight, were treated with the DIRT program. Significant improvements in OCD occurred for four of the five patients. Improved patient insight and reduction of perceived threat from contamination are possible reasons for the success of DIRT. Poor insight has been identified in patients not participating in or responding to behavior therapy. These individuals firmly believe risk of contamination is real and find it too stressful to participate in exposure therapy. DIRT targets threat-related beliefs for contamination obsessions and improves patients' insight and ability to more accurately assess real risks. Researchers conclude that behavior therapy with exposure and ritual prevention remains the treatment of choice for compulsive washing/cleaning behavior, but DIRT may help those with treatment-resistant OCD.

Abstractor's Comment:

While the authors assert that the DIRT program has no exposure component, the discussion of contamination and germs is an exposure exercise that may explain part of the program's benefit.

Group behavioral therapy of obsessive-compulsive disorder: seven vs. twelve-week outcomes

Depression and Anxiety, 13:161-165, 2001, J.A. Himle, S. Rassi, H. Haghighatgou, K.P. Krone, R.M. Nesse and J. Abelson

The length of time in CBT to achieve response is investigated, comparing the treatment outcome of seven versus twelve weeks of group CBT. The 7-week group (89 patients) met weekly for 2 hours. The first hour of the session was devoted to education and the second hour was devoted to behavioral treatment and formulation of behavioral exercises to be completed as homework. The 12-week program included a similar 7-week program augmented by five extra weekly 1-hour sessions, designed as a continuation of the behavior therapy planning portion of the group. In contrast to expectations, extending the duration of the group from 7 to 12 weeks did not enhance the outcome. In addition to saving time, the smaller number of sessions resulted in a cost saving of $350.00 per individual treated.

Abstractor's Comment:

More important than number of sessions is the ability of patients to embrace and engage in exposure and ritual prevention. Perhaps the best predictor of good outcome is willingness to move quickly and steadily to confront triggers of obsession and rituals (exposure) and then to forgo rituals (ritual prevention) as temporary relief of discomfort. While it isn't necessary to confront the most difficult triggers immediately, unwillingness to endure discomfort is a strong predictor of poor outcome with CBT.

OCD — After the Attacks

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turn them into true obsessions, the individual would have to desperately try to not have the thoughts.

The second way in which the general public has now joined with those suffering from OCD has to do with helplessness in the face of uncertainty. For years, experts have been predicting that sooner or later there would be a successful terrorist attack and we all walked around with no more than an intellectual acceptance of this. Terrorism was possible, but the fact it had not happened made us fearless. The destruction of the World Trade Center and bioterrorism has made terrorism a reality. Now, like anyone suffering from OCD, despite the fact we know the probability of something happening to us or our loved ones is slim, we feel threatened. Many are now overly concerned about air travel, train travel, receiving mail and chemical warfare. Some are taking precautions even though being killed in a car crash is far more likely. Are these individuals being more cautious about driving, are they considering whether or not each and every car trip is really necessary? Why not? Why can we accept the higher probability of being killed in a car crash, and not accept the unlikely risk of contracting Anthrax (which is also more survivable than a car crash)?

For coping with both this "new world" and with OCD, the answer has to do with acceptance. Acceptance can be defined as our expectations about the world being the same as reality. When our expectations differ from reality, we have problems, because we keep wishing and trying to live in a world that doesn't exist. We make ourselves unhappy by comparing the real world to the one we wished we lived in. Yes, we would all like to have the world return to its pre-September 11th state, but that won't happen. So we have to learn to find happiness in the world in which terrorism is a part of reality, just as most of us have found happiness in the world where car crashes might harm us or our loved ones. And this is the problem that every individual suffering from OCD has when s/he tries to obtain 100% certainty – that s/he is clean, that his/her violent thoughts don't mean anything, that s/he isn't gay, that the stove is off, and so on. People with OCD are too smart to believe in the world they wish for, the world of 100% certainty, but their agony arises from trying to make their fantasy come true.

We want protection where there is none. And all of us are mourning the loss of our old safe world. Mourning is the process of acceptance, of learning to live in a new world rather than a fantasy world, of missing the old, but not constantly comparing the present to how much better it would be if we could get back to the old way. It's sad to give up fantasy, but what choice do we really have? At our treatment center, we believe the core of OCD is the anxiety that arises from the inability to be 100% certain and the vain attempts to achieve this impossibility. We define the goal of treatment as learning to live with uncertainty without rituals or anxiety.

And the lesson is the same for all of us. There is no certainty, no 100% protection, no terror-proof environment. The recent past reminds us of the importance of cherishing what we have, our families, friends, and each and every moment, because that is all we have. The past, whether recent or distant, whether good or bad is no more than a memory. The future, though rich with possibilities, is always an if – we make plans for tomorrow, not because it will come, but because it might. So, we will try to take reasonable steps to increase our safety, but until tomorrow, their effectiveness is uncertain – we can only guess and hope we will cope with whatever comes. And so with yesterday gone and tomorrow just a hope, we all need to find the time to appreciate and escape into the present, the here and now, whether for seconds, minutes or hours. This appreciation, this living in the moment is the gift of acceptance.

Coping with the Attack on America: Help for Persons with OCD and Anxiety Disorders

Bruce M. Hyman, Ph.D., OCD Resource Center of South Florida, Hollywood, FL

The September 11, 2001 attacks upon the World Trade Center and the Pentagon have had an unprecedented effect upon many aspects of our daily lives. The horrifying, almost surreal nature of the attacks, the profoundly tragic loss of life, the massive destruction, have effected all of us in ways both subtle and profound. We are struck by feelings of outrage and despair for the cruel and senseless destruction of innocent life, followed by feelings of grief and anger toward the perpetrators of such a despicable act on our own soil. Questions surge through our minds - how could this have happened? Who are the people who did this and why? Will they do it again? How do I protect my loved ones and myself? Can I ever be safe?

For people suffering from an anxiety disorder, including OCD, or a mood disorder, such as, depression, the effects can be particularly disturbing, in some cases compounding already limiting and distressing symptoms. Let's take a look at how and why from a psychological perspective the horrifying events of September 11th may have a particular impact upon persons with OCD or an anxiety disorder in general.

OCD is an neurobiologically based anxiety disorder that has the following characteristics:

1. Pervasive thoughts, feelings or impulses, "obsessions" that provoke discomfort, fear or dread, especially regarding the possibility of harm, danger or threat to oneself or others. The repetitive performance of rituals and behaviors, called "compulsions," typically handwashing and/or checking things over and over, or constant requests for reassurance. Often, there is a magical or highly idiosyncratic relationship between the compulsions performed and the disasters they are intended to prevent or control. The person with OCD feels driven to perform these behaviors "just right" in order to contain or neutralize the anxiety of an obsessive thought or idea.
2. Overestimation of the risk of threat, harm and danger along with persistent feelings of doubt and uncertainty regarding the safety of oneself or others.

While not the defining symptoms of OCD, the following styles of thinking and examples of each characterize most people with OCD and anxiety disorders in general:

1. *Insistence upon perfect control* - "I must exercise nothing less than complete and perfect control over everything in life, especially that which can potentially cause harm or danger to me or those I love."
2. *All or nothing thinking, also called black-white thinking.* "If I'm not perfectly and totally safe (from potential harm), then I'm in utter danger and completely vulnerable to harm."
3. *Intolerance of uncertainty* - "Life and its possible adversities must be perfectly predictable and controllable at all times."
4. *Intolerance of risk.* "Risk involves the possibility of pain, danger and discomfort, therefore, I must avoid it at all costs."
5. *Hyper-responsibility.* "I'm responsible for protecting others from every conceivable possibility of harm, danger or discomfort, or else I will be punished or suffer harshly for it."
6. *Negative prediction bias or automatic anticipation of negative events.* "Everything I fear may possibly happen, is certain to happen. Therefore I must remain constantly vigilant to bad things happening to me and others, and worrying all the time about it. I can NEVER relax."

It is not difficult to see how the present conditions of fear, uncertainty, and vigilance in the face of our nation's international war on terrorism can wreak havoc on individuals who, in a sense, *already* live every day of their lives as if they were in a "war zone." The heightened state of fear, uneasiness and vigilance existing in our country today is not unlike the everyday experience of persons with OCD and anxiety disorders! However, while the "enemies" of persons with anxiety disorders are based upon distorted perceptions of risk, harm and danger, our nation now has a REAL enemy and REAL threats to face, pursue and destroy.

Perhaps most deeply affected by the events of September 11th are our sense of security and safety in our own home. Two hundred years of freedom from attack had fed a false sense of invulnerability and security in a dangerous world. It's easy to see how, in a nation suddenly placed under a state of heightened alertness, that OC's, like everyone else, feel increasingly anxious. Persons with OCD, and anxiety disorders in general, tend to absorb the anxieties around them, like a sponge absorbs water. Fear is contagious, and if anyone is going to "catch" the fear bug to an extreme, OC's certainly will.

The fact that our present enemy is not a specific entity, but rather a world-wide network of hidden terrorist "cells," some inhabiting our own cities, is particularly unnerving. Hidden dangers and threats lurking around in modern day life are often the focus of the obsessive fears of OCD because they raise the specter of a threat that can't be controlled or easily contained. Having but a vague sense of who the enemy is, where it resides, and what weapons of terror it intends to use, fuel

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the fear in all of us, and may compound already distressing OCD symptoms.

The fear of danger from dirt, germs and disease, particularly the AIDS virus, has been a focus of many with OCD. Today, with our nation facing the threat of bioterrorism, our electronic and print media are filled with daily reports of mail-in infestations and infections from diseases such as Anthrax, botulism and smallpox. For many, these newly publicized threats are likely to take the place of AIDS in the repertoire of the OC's fears and worries.

Living life as if the unlikely threat of harm or danger is likely to occur is a hallmark of OCD and other anxiety disorders. In light of the previously unthinkable events of the Pentagon being attacked, and having two of the world's tallest buildings fall, some patients may mistakenly use these unlikely events as "proof" to themselves that their OCD compulsions and rituals used to prevent highly unlikely, unthinkable events are now justified. Symptoms may become even more entrenched by use of the following false reasoning: "see...look what happened on September 11th! Now I'd better redouble my compulsive checking or washing, no matter how destructive and harmful these behaviors are!"

Other persons with OCD may attach highly idiosyncratic, anxiety-inducing meanings to the September 11th attacks. For example, a patient with scrupulousity or religious OCD may view the attacks as a "sign" of God's retribution for the "sins" of not having prayed adequately, or having thought the "right" thoughts, or doing everything "just right." Some OC's, with magical compulsions intended to ward off danger and disaster, may view the September 11th events as a "sign" of punishment for not, for example, placing the towels in the closet "perfectly."

A defining aspect of OCD is the presence of "insight." This is the awareness, on some level, at some time, that the imagined fears and worries are groundless, senseless, even silly. Patients who are doing well with their OCD, or even fully recovered, are able to access this "insight" more readily, even easily. However, during times of stress and uncertainty, the OCDer's degree of insight into his OCD may become more tenuous, vague, even non-existent. In such uncertain times as these, the reactive OCD mind resorts with increased intensity to the reflexive, automatic use of compulsions and rituals to manage the increased fear and anxiety. Compulsions may become more ingrained, time-consuming, and frustrating. For example, a washer may find that a previously effective two minute handwash just doesn't produce that feeling of "safety" anymore. The door lock checker who used to find his/her brain stifled after three checks, might now crave more and more "certainty" that everything is OK, and thus become stuck in a longer and longer checking cycle.

For some of us, the terrorist attacks have placed our pre-September 11th worries, fears and concerns in proper, more livable perspective. Suddenly, our petty angers, upsets and complaints toward our boss or in-laws seem so trivial in light of the misfortunes suffered by so many of our fellow citizens. Many persons with OCD report having these very same feelings. Ironically, however, I have also encountered some OC's who appear (by their own admission) blindly, almost blissfully detached from the dangerous events of the world around them, so caught up are they in their own obsessive preoccupations. For these patients, there is little time or energy to focus upon the international threat of terrorism and existing state of war, when there are doors, stoves and locks to check and recheck, and children, pets and parents to protect from harm and danger! OCD, at its worst, is a disease of all consuming self-preoccupation!

Certainly, in light of the events of September 11th, many OC's have found the present state of war mentally and emotionally taxing; and as a result, find themselves struggling with an increase not only in their OCD symptoms, but in symptoms of disorders that frequently accompany OCD as well, including depression, panic disorder, post-traumatic stress disorder. It's as if the available emotional resources for coping with life plus their anxiety disorder have become seriously depleted. Symptoms of lowered energy level, disrupted sleep patterns, changes in appetite, feelings of helplessness and hopelessness, poor concentration and loss of interest in previously enjoyed activities are all classic symptoms of depression and should be taken seriously. Persons with accompanying anxiety disorders, such as panic disorder, phobias and post-traumatic stress disorder, may find themselves suffering an increase in nightmares, flashbacks to previous traumas, moodiness, agitation and irritability, social withdrawal, and physical (somatic) complaints.

Coping in Troubled Times

The following are some suggestions for managing one's anxiety disorder in light of the present uncertain and fearful times we are living in:

1. Recognize that an increase in symptoms since the Sept. 11th attacks is normal and expected. Do not be alarmed that your symptoms have worsened, even in spite of all your efforts to prevent it. In time, your symptoms should return to their pre-September 11th levels. It is a good idea to have a "check in" session with a mental health professional familiar with OCD and anxiety disorders. The support of your therapist can be reassuring and fortifying in the face of the worries we are all confronting. If further intensive treatment is needed to stabilize the condition, pursue it according to your therapist's recommendations. Perhaps a medication adjustment is needed, or perhaps a review of CBT principles to prevent further flare-ups of your OCD symptoms.
2. Maintain daily routines and schedules. Routines provide a sense of "normalcy," comfort and stability. They are helpful in diverting you from focusing upon your obsessive thoughts and worries.
3. In times of uncertainty, take control of what you can reasonably control. You can't be in complete control of the dangers we face, nor can you control the world situation day to day. Accept it. But you can control that which is in your immediate power to control. Tending to your responsibilities effectively, your job and your family, can give you a sense of control.
4. Gain control by thinking, not just reacting. Hundreds of people, upon learning of the threat of bioterrorism, are purchasing gas masks and hoarding antibiotics, having no idea how or exactly in what situations they should or can be used safely. Similar actions are of psychological benefit, but provide no real benefit, are wasteful and potentially dangerous. According to experts, more productive is to get a flu shot, set up a safe room in your home, and put together a two week emergency survival pack (as if you are preparing for a hurricane or earthquake).
5. Join or start an OCD or anxiety disorders support group. This can be very valuable. Making connections to persons with similar problems is very comforting and strengthens coping capacities. Contact the OCF regarding how to start an OCD support group.
6. Give yourself permission to grieve, cry and release the tensions that have been built up over the past several weeks. Often sharing your honest, true feelings with others makes a difference.
7. Take a TV News Break. We've all been glued to our TV sets for the latest news on the war. But every now and then, come up for air, turn off the TV news, and do things you normally enjoy.
8. Find something positive you can do. Give blood. Donate money to help victims of the attack. Join efforts in your community to respond to this tragedy.
9. Manage fear by not focusing upon "what's possible", in favor of focusing upon "what's probable." Thinking about the present dangers in terms of "what's possible" only feeds fears unnecessarily. From this perspective, ANY conceivable disaster, from nuclear bombs, smallpox infections, even a terrorist climbing into our bed at night, are "possible" (yes, here in south Florida, where some terrorists lived, some people DO think this way). In fact, the anxious mind is so creative, we can easily scare ourselves to death! Instead, keep focused upon "what's likely", what's most possible, plausible, feasible. Battle your fears with good, solid information regarding the true risks and dangers we face. Few of these threats, including bioterrorism, while scary, are actually likely to affect any one of us.
10. Keep your sense of the risks in proper perspective. Remember, despite all the mass hysteria regarding bioterrorism and the Anthrax scare, the postoffice delivers over 30,000,000 pieces of mail per day, and to date, seven people have beeninfected and four have died. While the loss of any life is deplorable, the actual risk ofphysical harm while driving your car to the shopping mall is much, much higher than the risk of getting Anthrax from tainted mail.
As for flying, at any one time, there are over 5,000 airplanes in the sky and 23,000 flights per day. The chances of dying in an airplane mishap remains astronomically low and security efforts are at an all-time high.

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11. Seek professional help if you find yourself unable to cope and are experiencing symptoms of depression or a worsening of you OCD symptoms. Perhaps a few supportive therapy sessions, or a medication adjustment could make a difference in the way you feel.

Most of all, realize that uncertainty and danger are what people in many countries live with day to day. We, in the USA, are not accustomed, as a nation, to the challenge of carrying on with "grace under pressure" (Hemingway). It will take time for us all to adjust to the new realities of life. As such, we will eventually "habituate" to the tensions and uneasiness we feel and resume our lives with a greater sense of purpose and resolve.

Managing Life's Ambiguities Post 9/11

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In general, when real life delivers a crisis, people with anxiety disorders and specifically those with OCD tend to manage this crisis somewhat more effectively than the population at large. The very nature of Obsessive Compulsive Disorder is the mind's relentless and endless effort to process and prepare for the most extreme nightmarish situations. The anxious mind compels people to mentally anticipate the worst possible scenario, not the moderately negative outcomes which life typically delivers. Our "normal" world usually delivers circumstances which don't come close to approaching the level of negativity for which people with OCD consistently prepare.

Subsequent to the September 11th tragedy, it has been my observation that the general public is reacting in a more exaggerated way than would a person with OCD. The general public was completely unprepared for this crisis. So now, for those who do not have OCD, any white powdery substance, flying planes, and being above the tenth floor of any building are reminders and a forecast of their vulnerability. In contrast, people with OCD tend to be biochemically fixated on their pre-attacks compulsions and obsessions. For example, they could be a lot more distressed about the potential of suffocating their own child or of the possibility of being gay than with managing the ambiguities of white powder or low flying planes.

There is, however, a segment of the OCD population that will be noticeably more affected by these events. Persons with OCD who suffer from contamination concerns are going to be more prone to cleaning off all dust particles and to washing their hands vigilantly. They might even be considering buying protective devices such as gas masks or antibiotics. People who were afraid of flying before 9/11 because they feared the plane might crash will probably be more unsettled by the hijackings than OCDers who hated to fly because they thought they would have a panic attack.

An interesting phenomenon took place for many of my OCD patients in the weeks following the September 11th tragedy. A very dramatic trend emerged: sufferers who had not yet received the benefit of behavior therapy tended to either ignore, or devote no more than five minutes of session time processing the tragedy. Instead, they wanted to devote the entirety of their therapy sessions to the ongoing process of their unique therapeutic agenda. This reflects the intense and overwhelming need experienced by the person with OCD to find relief from the urgent dilemma created by his/her obsessional focus.

A recent theme, and I think a very relevant concern, for a number of my patients who are more of the obesssional nature, is the threat of what might be termed "blood lust." There is a tendency for humans to find a sense of exhilaration or excitement at the idea of going past a car accident and seeing some unknown horror. It is also the case that some people get excited by the prospect of the death toll being exorbitantly high or find a thrill in watching the inconceivable sight of the WTC buildings collapsing.

For those persons with the purely obsessional type of OCD, who are concerned about their own righteousness of character, this human tendency to be attracted to horror provides a fairly new spike theme. This spike involves believing that one has a personal defect in character as indicated by their interest in sights and information on crisis, new traumas and human suffering. It is important to understand that this appeal of the horrific is basic human nature. We tend to be somewhat disappointed on an emotional level when we hear that a hurricane veered off course and is not going to kill hundreds of people in low-lying areas in our neighborhood. It is important to understand that we all found a certain fascination in watching the WTC buildings collapse or in fathoming what it might be like to have been on those planes that slammed into the buildings. From a therapeutic viewpoint it is important for us to let go of finding an answer as to whether or not this basic thrill, this basic tendency for humans to find fascination and appeal in the potential horrific suffering of others, is indicative of severe psychopathology and character deficits, or indicative of nothing more than our basic human curiosity. Specifically, we are better off not seeking answers to such questions, but rather to accept the sometimes surprising complexities of being human.

The tragedy of the September 11th disaster has unfortunately created an opportunity for all of us in the general public to experience the preoccupation, anxiety, and torment related to the uncertainty of the future that OCD sufferers live with consistently until their disorder is appropriately and effectively treated.

Aftermath

Bradley C. Riemann, Ph.D., Rogers Memorial Hospital, Oconomowoc, WI

Clearly, the events of September 11, 2001 and their aftermath would be considered a "stressor" for our whole nation. What effect will this have on individuals with OCD or those predisposed to develop OCD? Stress from any source typically increases OCD symptoms in those suffering from the disorder. This seems to occur for two main reasons. First, stress directly increases the frequency and intensity of obsessions and compulsive urges. For example, students with OCD will report more difficulty with their disorder during finals week or accountants with OCD during tax preparation time than during typical times. Some of the individuals we are currently working with have reported a heightened level of OCD symptoms, but some have not. Whether the recent events increase OCD symptoms or not apparently depends on what the perceived impact of these events are on an individual's life (i.e., do they see the events as a stressor or not). Second, stress can indirectly increase OCD symptoms by absorbing a person's time and energy away from practicing the skills they have learned to manage their OCD, thus increasing their symptoms.

It appears that stressful life events may also play a role in triggering some cases of OCD. There is not nearly as much data to support this notion, but in some studies as many as 50-60% of OCD sufferers reported experiencing a stressful event around the onset of their OCD. Therefore, it is possible the recent events may play a role in the development of OCD for some. It should be made clear, however, that the events themselves most likely did not "cause" the OCD, but that in an individual who was predisposed (most likely biologically) to develop OCD the stressor may have acted as a spark that ignited the fire.

Impact of the Attacks

Christina J. Taylor, Ph.D. Sacred Heart University Fairfield, CT

The psychological aftermath of the September 11 terrorist attacks continues to unfold for all of us, including those suffering from OCD. While the full impact of the tragedy remains unknown, particularly as cases of Anthrax contamination heighten our fears, I can see that the terrorist attacks have affected some of my OCD patients.

The effects have been both positive and negative. One of my patients who suffers with contamination obsessions was so moved by the devastation at the World Trade Center that she organized the donation and personal delivery of supplies to the rescue workers in lower Manhattan. Her concern and compassion for the rescuers took precedence over fears that might ordinarily lead to withdrawal and avoidance. I have seen this type of fortitude among other patients as well. In the face of the unimaginable horrors unleashed on so many, they have been able to put their own fears into better perspective. As a result, they have been coping better with their OCD.

Some have, however, experienced a worsening of their symptoms. This has happened to people whose OCD focuses on taking responsibility for preventing harm to others. For these individuals, their compulsions to pray, repeat, check and ritualize in other ways have been greatly fueled by the terror. One patient whose relative didn't make a scheduled meeting at Windows on the World that fateful morning is struggling with the burdensome belief that his compulsive prayer rituals might be the reason his relative survived. This means he has an obligation to continue.

These events and their consequences have put up new barriers to this man's recovery and the same is true of many others. But at the same time, I have noticed that every one of my patients continues to fight the good fight against OCD.

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