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OCD Newsletter

10th Annual Conference!

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Funding Research: One of Our Most Important Missions

Dear Friends,

It looks like it is getting to be a yearly ritual for me to implore you to help the OC Foundation with a donation to support research into the causes and treatment of OCD. Once again, the OC Foundation has made remarkable progress in many areas. But we need your help to fund the research that needs to be done to find more effective treatments for OCD.

Despite more publicity about OCD and related disorders, only the sufferers and their families can understand the true pain and disability caused by these illnesses. As I have noted in the past, many young researchers throughout the world approach me about whether or not significant funds will be available to help them study OCD and related disorders. These young researchers are interested in OCD, but they tend to go into areas where research funds are obtainable. The more money we are able to raise, the more likely brilliant young researchers will be to gravitate towards investigating these potentially crippling disorders. If we have funds for these young people early on in their careers, they will have funding to gather pilot data, allowing them to apply for and eventually obtain Federal grants. So, our initial relatively small investment in them may pay enormous dividends for the OCD community for decades to come. Federally, OCD is underrepresented in grants that are competitively awarded. This is likely a direct result of the small number of investigators applying for such grants.

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. In 2000, I noted that the funds raised were quite modest. That year,

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When Reassurance is Harmful

By Paul R. Munford, Ph.D.
Anxiety Treatment Center of Northern California

People with OCD worry that their obsessional fears will come true. To ease this distress they ask other people, usually family members or close friends, over and over again to reassure them that it won't happen. Because obsessional fears are always unrealistic, the family members or friends (and even therapists) tell them there is no need to worry; nothing bad is going to happen. For instance, it is quite common for people with fears of hurting others to seek reassurance that they are harmless; for people with fears of engaging in inappropriate sexual acts that they will not lose control; and for fears of committing blasphemy that they will not be punished. Typically, they get the reassurance that they want; but its effects don't last because the fear returns with the next obsession. These repeated reassurance requests are actually compulsions because they provide only temporary relief from the obsessions. And, like other compulsions, they prevent exposure to the fear which is necessary for recovery. Even though offering only temporary relief, the reassurance is rewarding enough to keep the person repeatedly seeking more of it. Here's the first paradox: the more reassurance received, the more reassurance wanted.

It eventually becomes apparent to those in the reassurance exchange that their efforts are not only useless for managing fear but also lead to interpersonal strife. Reassurance is not helpful; it's harmful. For example, I worked with a woman who feared that her three-year old daughter was not her biological offspring but someone else's; her baby had been switched in the hospital. During the early stages of fear, she called the hospital requesting confirmation that the child was hers, and was assured that indeed she was. This satisfied her for a few days; but as the doubt returned,

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From the Foundation

Dear Readers,

I wanted to share with you a conversation I had with Andy Breckman, the executive producer of "Monk," about detectives, heroes, the creative process and OCD.

Andy Breckman, the executive producer and creator and writer of the hit TV series, "Monk," has always loved detective stories. That's what he told me in a recent telephone interview. He's read hundreds of them and his favorite detective is Sherlock Holmes. Actually, Breckman told me Sherlock Holmes is the inspiration for Adrian Monk.

Breckman, who has been involved in writing and producing television series since 1980, explained that the pipe-smoking master sleuth was the prototype for all subsequent fictional detectives from Philip Marlowe to Ironsides. "If you analyze detective stories, you realize that every great fictional detective is flawed or has suffered a great loss or has a problem to overcome. Holmes was a drug addict," Breckman pointed out. "Overcoming the problem or filling the loss, as much as solving the mystery, is what makes them interesting, heroic, appealing. They also all have almost frighteningly brilliant minds," he added.

Creating such a Holmesian character was his goal when he and David Hoberman, the show's other executive producer, started thinking about writing a detective series almost five years ago. "It was David's idea to give their detective OCD. We were casting around for the central character's problem. Obviously, alcoholism and drug addiction had been done again and again. After seeing Jack Nicholson in 'As Good As It Gets,' Hoberman suggested that our hero have OCD," Breckman explained.

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Bulletin Board

New Childhood Obsessive-Compulsive Disorder Study

The National Institute of Mental Health has just begun a new study for children with Obsessive-Compulsive Disorder. The study is enrolling boys and girls ages 4-12 who have experienced a recent onset of OCD (within the last 6 months) and who live within a 4-hour commute of Bethesda, MD. The children will be followed at 6-week intervals for 2 years. The purpose of the study is to learn more about childhood Obsessive-Compulsive Disorder in order to provide early identification and better treatment for children suffering with OCD. The hypothesis of the study is that two groups will emerge: 1) children with a gradual onset and stable course of OCD who will comprise the "persistent" group, and 2) children displaying an acute onset and episodic course of OCD, the "episodic" or PANDAS group.

Benefits to participants and their families include psychiatric, neurological, and physical examinations; psychological testing; and MRI scans. Participants and their clinicians will have the opportunity for consultations regarding medications and cognitive behavioral therapy with clinicians who specialize in childhood-onset OCD.

All care is free of charge. Travel stipends are available to families who reside over 90 miles from the NIMH. Dr. Susan Swedo is the Principal Investigator. For more information and a confidential screening, please call Maggie Pekar, M.A. at: (301) 496-5323, or email PANDAS@codon.nih.gov.

Research: The Hope for Tomorrow

Families with Obsessive Compulsive Disorder are invited to help scientists learn more about the causes of OCD. A team of scientists at six academic institutions is investigating genetic factors which may increase the susceptibility to OCD. Recent advances in molecular biology and statistical genetics make it possible to identify and describe specific genes that may cause complex diseases such as OCD. We are seeking families with OCD to help us conduct these studies.

YOU CAN HELP!!

If at least two members of your family are diagnosed with OCD or exhibit symptoms, your family might be eligible for this nationwide study. Participation includes a confidential interview and a blood sample. The interview will be scheduled at a time and place convenient for the participant. Participants is vital and DOES make a difference. Families may be referred by a clinician or may contact us.

To learn more about the study, please contact (collect calls accepted):

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The OCD Collaborative Genetics Study includes Brown University, Columbia University, Johns Hopkins University, Massachusetts General Hospital, National Institute of Mental Health and UCLA

Multi-Center Trial of Ziprasidone (Geodon) Augmentation in Serotonin Reuptake Inhibitor-Resistant Obsessive-Compulsive Disorder (OCD)

The purpose of this research is to obtain data or information on the safety and effectiveness of ziprasidone (Geodon) for the treatment of obsessive-compulsive disorder (OCD) in patients who have not had a satisfactory response to an adequate trial of at least one anti-OCD medication (a serotonin reuptake inhibitor [SRI]). Ziprasidone has been approved by the federal Food and Drug Administration (FDA) as safe and effective for the treatment of schizophrenia. We have decided to do this study because a medication called risperidone, which has actions similar to those of ziprasidone, has been found effective in relieving the symptoms of OCD in patients whose symptoms have not responded to an SRI alone.

Patients eligible to participate in this double-blind study are randomly assigned to receive augmentation of their SRI treatment with

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Correction

The intensive treatment program described in the Fall 2002 newsletter should have been identified as the Obsessive Compulsive Disorder Research & Treatment Clinic at the Stress & Anxiety Disorders Clinic in the Department of Psychiatry at the University of

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 8,000 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 treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore; and other programs.

Augmentation Strategies For Difficult to Treat Obsessive Compulsive Disorder

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The majority of patients with OCD can be helped with current medication and behavioral treatments. The primary medication treatment for OCD involves targeting the serotonin system in the brain. However, the fact that many patients have partial resolution of their symptoms and others little to no improvement suggest other chemical systems may be involved. This underlies the strategy of augmenting, or adding, a second medication in patients who have only partially responded to a serotonergic medication alone. This article will review strategies that can be used in the patient who has 'difficult to treat' OCD. Above all, it is crucial that patients receive cognitive behavior therapy or CBT because this is the best augmenting technique available.

Primary Drug Treatment of OCD

A patient with OCD should receive an initial treatment course with one of the primary serotonergic medications. These medications include clomipramine (Anafranil), fluoxetine (Prozac), sertraline (Zoloft), fluvoxamine (Luvox), paroxetine (Paxil), and citalopram (Celexa). Escitalopram (Lexapro) is a new SSRI that has not been studied in OCD, but it will likely be effective. Another drug, venlafaxine (Effexor) may also be effective although there have not been any large controlled trials in OCD. There is no evidence that one drug is best when studying large groups of patients, but one or two medications may work while the others may have little or no effect when looking at a single individual. Therefore, multiple drug trials at high dosage for about three months each are necessary to determine which drug is the most helpful with the least side effects. Studies have shown that an adequate trial of one of the above medications, combined with appropriate behavioral treatment, will be effective in the majority of patients, with at least partial, if not substantial, improvement after a few months.

Reasons for Poor Response to Treatment

One reason for an inadequate response is that an inappropriate treatment has been used, such as, psychodynamic psychotherapy, electroconvulsive treatment, or use of a different type of psychiatric medication for the initial medication trial. Factors associated with a poorer response to treatment include: poor compliance with treatment, concurrent severe depression, and severe personality disorder. The behavioral therapy component to treatment is demanding and requires the patient to be compliant both in the treatment sessions and outside of the sessions during 'homework'. Noncompliance with behavioral treatment is a common reason for treatment failure. Severe depression can interfere with the learning process in behavioral therapy, but the serotonergic medications are also powerful antidepressants.

Patients who strongly hold onto the belief that their rituals are necessary to avoid a future catastrophe (referred to as 'overvalued ideas') have a poorer outcome with behavioral treatment alone. In addition, one type of personality disorder referred to as schizotypal personality disorder is associated with a poorer outcome. Another reason for poor response to treatment may be an incorrect diagnosis. There are other psychiatric conditions which may have OCD-like features, although OCD in and of itself is not the key problem in these other conditions. Examples include schizophrenia and obsessive-compulsive personality disorder, in which the treatment approaches may be very different. As described above, other conditions can exist concurrently with OCD. In this case, the appropriate management may involve treating both OCD and other conditions simultaneously. A thorough history is required to identify factors, such as, previous inadequate treatments, incorrect diagnosis, poor prognostic factors, or co-existing psychiatric conditions.

Augmentation Strategies

Numerous studies and case reports have demonstrated that various medications added to a primary serotonergic agent may result in improvement in some cases of treatment-resistant OCD. There are not enough data to definitively state which is the best augmenting drug. We will review some of the data below.

Mood Stabilizers

Lithium, a mood-stabilizing medication, when added to a tricyclic antidepressant, has been shown to help in depressed patients without OCD who have not responded to an antidepressant alone. This same strategy of adding lithium to treatment-resistant OCD has had conflicting results. One well-designed study comparing lithium to placebo addition to a serotonergic medication found a small degree of improvement with lithium compared to placebo, although the improvement appeared not to be 'clinically meaningful' with regards to improvement in functioning. This study suggested that there may be biological differences between OCD and depression, and that routine use of lithium addition in treatment-resistant OCD was not supported by this study. There is a growing body of literature suggesting that Neurontin (gabapentin) may be an effective augmenter of an SSRI. Neurontin has few side effects, and, overall, appears to be a safe, easy to titrate, well-tolerated drug.

Cytomel

Another study looking at thyroid hormone augmentation of a serotonergic agent in OCD had similar results to the lithium augmentation study – the results are not strongly suggestive that it is helpful.

Anti-Anxiety Medications

The addition of an anti-anxiety medication (i.e., Klonopin, Ativan, etc.) to a serotonergic agent may be helpful in patients who have difficulty tolerating the anxiety associated with behavioral treatment, although one study did not display clinically significant results in improving OCD severity. Cases describing the addition of buspirone to a serotonergic agent in treatment-resistant OCD have also demonstrated mixed results. A study in a small number of patients at the Massachusetts General Hospital comparing buspirone addition to fluoxetine with fluoxetine alone resulted in a clinically significant improvement in OCD symptoms in the buspirone addition group when buspirone was continued for at least 8 weeks. However, in a differently designed study at another site examining buspirone addition, no clinically significant improvement was seen with buspirone addition.

Clonidine

Clonidine, a medication used in the treatment of high blood pressure, has been reported to be an effective treatment for OCD symptoms in the context of Tourette's Syndrome. Again, case reports and studies of adding clonidine to a serotonergic medication have had mixed results in treatment-resistant OCD and the side effects usually are limiting.

Older Antidepressants

Sometimes older antidepressants are added to an SSRI to boost antiobsessional effects. Trazodone has been reported to improve the severity of OCD in some patients when it was added to fluoxetine, although many patients could not tolerate the combination

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OCD, ERP & Me: One Person's Struggles and Improvement

By Robert J. Penella

One of the advantages of this newsletter is that laypeople who suffer from OCD can share their experiences with each other. Our symptoms can often make us feel isolated and "weird," even ashamed. Going to a doctor or therapist is going to an "authority figure," who, we usually assume, knows about our suffering only from books and through his or her practice. It's consoling to hear from other laypeople out there who have had experiences similar to one's own. It's encouraging to hear from people who have managed to get some control over their disorder. This is the spirit in which I share some of my own experiences with OCD.

I began suffering from obsessive thoughts at the age of 12. After a two-year remission of my symptoms, the OCD returned when I was 20 years old. By this time, I was aware that I had a psychological disorder and began classic psychoanalysis. I didn't know that this would be the beginning of 12 years I would spend, intermittently between 1970 and 1996, with a number of psychotherapists – the analyst, two psychodynamically oriented therapists, and a cognitive therapist.

My obsessive thoughts consisted mainly of unwanted and repulsive sexual images. More recently I have also been experiencing violent thoughts, although many of the sexual thoughts themselves could better be described as violent rather than erotic. I have also experienced the mental torture that comes from wanting absolute certainty in making a decision, being endlessly pulled back and forth in my mind by arguments in favor of and against a course of action. For many years I considered myself a pure obsessional, since I had none of the usual external compulsions. But it gradually became clear to me that I had been having internal mental compulsions all along. I would often have the need to check back mentally on an attack of obsessive thoughts, trying to assure myself that I didn't want them and that I had fought them valiantly. I might have had to repeat this ritual of self-assurance for half an hour or more, trying to get some relief from the anxiety and frustration that accompanied the obsessive thoughts, just as a handwasher tries to get some relief through repeated handwashing.

Although I learned some things about myself in the 12 years of talk therapy, I can say in retrospect that it did nothing to relieve my OCD symptoms in any significant or permanent way. My worst crisis occurred, in fact, during my last period of talk therapy. I felt that I was on the verge of a breakdown and, for the first time in my life, sought the help of medication, against the recommendation of my therapist, whom I left shortly afterwards. With the help of Anafranil (clomipramine), at a top dose of 150 mg. a day, I got back on my feet again. But although the medication calmed me down physically as well as mentally, allowed me to sleep well, and softened my symptoms, the OCD was still there. It was then that I sought out behavioral therapy and the exposure and response prevention method (ERP).

ERP in the last three years has literally changed the quality of my everyday life. It is the only technique that has significantly weakened, if not totally eliminated, ingrained patterns of experiencing and unsuccessfully trying to cope with obsessions. I wish that I had turned to it much sooner! For a long time I was influenced by the prejudice that talk therapy was the only serious approach to mental disorders. But partly out of desperation and partly because of information I was getting from the Obsessive Compulsive Foundation and from books such as Gail Steketee and Kerrin White's *When Once Is Not Enough* (1990) and Edna Foa and Reid Wilson's *Stop Obsessing* (1991), I finally turned to a behaviorist and got to work.

ERP is a simple, if counterintuitive, method. Instead of fighting or fleeing from anxiety-provoking obsessions, you wallow in them; and instead of engaging in compulsive, anxiety-reducing responses to the obsessions, you refrain from them. To reduce anxiety in the long run, you intensify it in the short run. You put your head right into the lion's mouth instead of spending your life running away from the beast. Under the guidance of my therapist, I worked up a hierarchy of my obsessive thoughts and images, from least upsetting to most upsetting, and began to do two 30-45 minute exposure sessions a day, working my way up the hierarchical ladder. I would lie on my couch, close my eyes, vividly think the anxiety-provoking thought, exaggerate it, and let myself feel the discomfort, which would lessen as the exposure continued. Meanwhile, when obsessions occurred during the day, I tried to refrain from compulsive mental rituals of self-assurance. For the first time in 30 years, I was experiencing my obsessions in a different way. I was habituating myself to them and to the anxiety they provoked. Within weeks after I began ERP, the frequency, the intensity, and the duration of my obsessions began to lessen. After about six months I got a good enough result that I no longer needed to do exposures as frequently as I had been doing, though I continue to do them in persistently troublesome situations, as I explain in the next paragraph, and occasionally for maintenance and reinforcement.

My therapist had insisted that it was essential to get to the top of the hierarchy – that is, to expose eventually to the most anxiety-provoking thoughts, however difficult this might be. I had done this and had reached a good level of improvement. But, encouraged by this improvement, I felt that I needed and wanted to go further. What could I do to push forward? It soon became clear to me that, although I had reached the top of the hierarchy in my deliberately induced exposure sessions and had achieved a reduction of my symptoms from this technique in the ordinary course of the day, I was still having a lot of trouble with my obsessions in certain places, in certain social settings, and in the midst of certain behaviors. I saw that, for me, "reaching the top of the hierarchy" meant "taking my exposures into the workplace" – going from doing self-induced exposures on my couch to doing them when my obsessions occurred spontaneously in "real life" in the troublesome places and situations. I had already begun, almost from the start and with good results, to do "mini-exposures" when a routine obsessive thought occurred during the day. Now I had enough confidence to begin doing on-the-spot exposures in places and situations that were most anxiety-provoking to me. Progress here is slower because I can't create most of these situations at will. But progress is occurring, and I am moving to a higher level of improvement. The principle is the same: go into the anxiety, and don't spare yourself any discomfort. It will lead to much, much less discomfort. My current dose of clomipramine is only 25 mg. a day, and I will probably soon be able to come off of it completely.

I have also used a simple form of meditation with helpful results. You simply get into a comfortable position, focusing on and counting your breaths. This is a good relaxation technique, and we can all benefit from that alone. Stray thoughts will occur during meditation, and these will undoubtedly include an obsessional's standard repertoire of anxiety-provoking images. When this happens, one should calmly return to breath-counting. The idea is to become detached from and indifferent to any thoughts that occur. No judging, no fighting, no compulsive responses. This is a useful supplement to exposure, because our goal is to be able to let troubling thoughts pass by without engaging with them. If you can achieve this detachment in meditation, it should help you to be able to do the same in everyday life.

Another thing that can be done during meditation, or at other times, is to use reinforcing mental imagery. If you brainstorm, you will be able to come up with imagery that represents tranquility and mastery for you and points to

My Children Have OCD

By Marilyn Koenig-Lulloff

Like any mother, you want the best for your child. You want each of your children to be healthy, experience joy, and live life to their greatest potential.

I experienced five births and believed each of them to be healthy. At the time, I was unaware of anxiety disorders and only knew I had five "physically" healthy children.

When my third child, Roman, was about two years old, I started worrying about him. He seemed to be such an angry child and somewhat of a loner. He could play for hours by himself and be quite content. But he would get very upset if you moved his toys out of line or disrupted his play. Because he had two older sisters, I just assumed at times they were irritating him. But, still, the anger seemed excessive. He would play in dirt like any other child, but wanted his hands washed as soon as he was done. He had unusual fidgets, a fear of stickers, and would change his shirt when anybody touched him.

At the ages of three and four, I recall him being exceptional at telling stories about what his house was going to be like when he was older. He would tell about the same extravagant house every time he spoke, adding greater detail each time. I was very confused. In some areas he seemed quite intelligent. In others, he appeared to be struggling. I don't know if I could have done anything earlier, except to understand, but we went on with life and let him play on his own when he wanted to and tried to discipline him when he was angry.

In the meantime, my husband was dealing with "work-related" stress. He sought help from a therapist and was told to get more exercise.

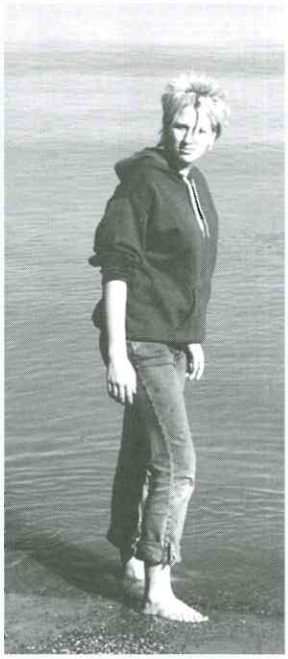
After Roman started school, we became concerned that he had a learning disability. He didn't mix well with other kids and was behind on his basic skills. He was tested at the school and the results showed he was "normal". Maybe all he needed was to mature and he would catch up with the other kids.

He continued in first grade with the same struggles. His teacher at the time thought he could possibly have ADD (Attention Deficit Disorder). She bluntly told me at the time: "He will probably need to be on medication the rest of his life."

Before I go on, I want to say that I don't blame the school for anything. Though I don't believe that specific teacher had the right to diagnose him the way she did, I trusted what they knew. And, at that time, any child who couldn't pay attention in class was diagnosed with ADD or ADHD (Attention Deficit Hyperactivity Disorder). It was a matter of not being educated about other anxiety disorders.

Well, needless to say, I cried all the way home and my husband and I contemplated our options. When Roman was in second grade, we found a psychiatrist who did diagnose our son with ADD. As most children diagnosed with ADD, Ritalin was prescribed. We thought this was our answer. But sadly, Roman did not respond well to the medication and we were back to square one.

My husband's anxiety was also increasing at this time. He ultimately was diagnosed with OCD. That was the first I had heard of this disorder. As I stared reading the literature, I was amazed by the symptoms and how they almost matched my husband's behavior exactly. Roman's symptoms seemed similar. He, too, was also diagnosed with OCD and depression. They were both prescribed antidepressants.



As I've discovered over the last few years, the medication can help greatly; but that is only the beginning. Therapy at that time consisted of visits to the psychiatrist and going back and forth with various medications. I tried a few different types of "behavior" therapy, but no one seemed to specialize in OCD. Also, my husband and I did divorce at this time, so Roman and his siblings were under additional stress.

In sixth grade, Roman was still not connecting with many children socially and he was also struggling academically. I tried to understand the disorder, but not having it myself made it difficult. In the middle of sixth grade, his mood seemed to change. He seemed more depressed and withdrawn. It seemed to me that he probably needed a change in the dosage of his medication or a complete switch. He had been on three to four different medications by then; and I was getting more and more frustrated.

I spoke with his psychiatrist about taking him completely off his medication and starting from scratch. I really wanted to see where he was at emotionally and his psychiatrist agreed. We slowly weaned him from his medication. That is when I realized the severity of his OCD and depression.

The public school Roman attends has been wonderful to work with. There have been exceptional staff members who have also tried to understand him and help him in any way possible. It was during the time he was being weaned from his medication that I received information about Rogers Memorial Hospital from counselors at his school. I see it as fate that I was given this information at this point. The day I will never forget. The day my 11-year-old son wanted to commit suicide.

I figured out very quickly where Roman was emotionally. I knew he needed help and I knew I needed somebody to understand him and help him. I called the number for Rogers Memorial Hospital and he was admitted the next morning. This is where I finally came to understand his disorder and we started to get control.

Roman was released a week later and started eight weeks of intensive therapy. Four days a week, a two-hour drive both ways. But I would do it again. It was such a relief to find the help we were searching for.

Roman now has the tools to work with his OCD, though he struggles because of his age and maturity, to grasp all it entails to control it. It's doubly hard for him because he is also suf-

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 compulsive shopping, an OC Spectrum Disorder.

Compulsive shopping is often referred to in jokes. As these studies show, it's no laughing matter. The relationship between compulsive shopping and OCD is still uncertain, but serotonin reuptake inhibitors (SRIs) that are clearly effective in OCD seem helpful for some who struggle to control their shopping, despite the field's inability to confirm this observation with well-done studies.

Compulsive buying disorder: definition, assessment, epidemiology and clinical management

CNS Drugs, 15:17-27, 2001, D.W. Black

This is an excellent review of compulsive buying disorder written by Donald Black, M.D., a national expert on the topic. Compulsive buying disorder, defined by excessive or poorly controlled preoccupations, urges or behaviors regarding shopping and spending which lead to adverse consequences, affects from 2 to 8% of adults in the U.S. The majority of those affected are women and onset usually occurs in the late teens or early twenties. Clothes, shoes, jewelry and make-up are the most common items purchased by women. Purchased items are generally not large and expensive, but these items are typically purchased in quantities that cause problems. Frequently there are co-occurring mental disorders, particularly, depression, anxiety, eating disorders, substance abuse and personality disorders. Recommended treatments are psychotherapy, cognitive-behavior therapy, 12-step programs, debt consolidation and credit counseling, and medication treatment with SRIs.

Compulsive buying, compulsive hoarding, and obsessive-compulsive disorder

Behavior Therapy, 33:201-214, 2002, R.O. Frost, G. Steketee and L. Williams

Compulsive shopping is currently classified as an impulse control disorder. Some experts suggest that it should be considered an OC Spectrum Disorder because it resembles the experience of OCD. Recurrent urges (obsessions) to buy are associated with increased anxiety (compulsions). Other experts suggest that there are two types of compulsive buying: OCD buying and impulse control disordered buying. This study compared 75 compulsive buyers to 85 non-compulsive buyers on hoarding and OCD symptoms. Compulsive buyers scored higher on both types of symptoms. Compulsive buyers also scored high on a measure of compulsive acquisition of free items, such as, brochures, lecture handouts, free newspapers and discarded trash. Researchers conclude that compulsive buying may be a variation of OCD, most similar to hoarding. They also propose that compulsive buying should be looked at as a component of compulsive acquisition that includes both buying and picking up free items.

Impulsive behavior in a consumer culture

International Journal of Psychiatry in Clinical Practice, 6:65-68, 2002, H.J. Hartston and L.M. Koran

Descriptions of two compulsive shoppers are given to illustrate some common features of compulsive shopping behavior, such as, lack of control, feelings of shame and embarrassment, low self-esteem and disrupted relationships. Compulsive shopping is compared to hoarding and to excessive buying during manic episodes of bipolar disorder.

Hoarded items are more often everyday, inexpensive things, and rarely associated with debt or excessive spending. Excessive buying with bipolar disorder tends to be episodic during manic episodes, differing from compulsive shopping behavior that is a continuous problem and also does not occur with symptoms of decreased sleep, increased energy, flight of ideas or other symptoms of mania. The authors contend that compulsive shopping is a valid impulse control disorder, clearly distinguishable from OCD hoarding and from excessive buying associated with mania. The article concludes with a brief review of psychotherapy and medication treatments.

Phenomenology and psychopathology of compulsive buying

International Journal of Neuropsychopharmacology

Of 119 inpatients diagnosed with major depressive disorder, 31.9% (38 patients) were also diagnosed as compulsive shoppers. Compared to depressed patients without compulsive buying, the depressed patients with compulsive buying were younger, more often women and more often unmarried. Interestingly, they were not more influenced by promotional advertising. Compulsive buyers did not seek sales and once entering the store, they did not change their choice of purchase more often than others. Compulsive buyers were significantly more often alone while shopping and purchases were significantly less used than expected.

The relationship between compulsive buying and eating disorders

International Journal of Eating Disorders, 32:107-111, 2002, J.E. Mitchell, J. Redlin, S. Wonderlich et al.

Previous studies have found unexpectedly high rates of eating disorders, especially binge eating and bulimia, in individuals diagnosed with compulsive buying. The purpose of this study was to further examine this relationship. Twenty women diagnosed with compulsive buying were compared to 20 controls. In contrast to previous studies, the prevalence of comorbid eating disorders or a past history of eating disorders did not differ between compulsive buyers and normal controls. This study did find a higher rate of substance dependence and substance abuse in the compulsive buyers; 52.6% of the compulsive buyers versus 10% of controls had problems with alcoholism or other substance abuse.

Compulsive buying severity: an analysis of Compulsive Buying Scale results in 44 subjects

Journal of Nervous and Mental Disorders, 189:123-126, 2001, D.W. Black, P. Monahan, S. Schlosser et al.

Evaluating the severity of compulsive buying, this study found differences between those individuals with severe versus milder compulsive buying symptoms. A major finding was that compulsive buyers with lower incomes had

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lems tended to have below median incomes ($20,500) and were less likely to purchase sale items. Increasing compulsive buying severity was also associated with increased occurrence of OCD, substance abuse, major depression and gambling. There was also an increase of avoidant personality disorder symptoms in those with more severe compulsive buying. Researchers speculated that this presence of avoidant personality symptoms may indicate that severe compulsive buyers, by nature shy, use shopping as a way to interact with the public.

Citalopram treatment of compulsive shopping: an open-label study

Journal of Clinical Psychiatry, 63:704-708, 2002, L.M. Koran, K.D. Bullock, H.J. Hartston et al.

At 12 weeks, 71% of 24 subjects (22 women and 2 men) treated with citalopram (Celexa) reported marked or total loss of interest in shopping, no preoccupation with shopping, easy disposal of all mail catalogs, discontinuation of Internet shopping, and ability to visit shopping malls without making a purchase. This high response is consistent with other open trials of SSRI treatment of compulsive shopping. During a 6-month follow-up, those continuing citalopram therapy were less likely to relapse than those discontinuing citalopram. Four of 5 responders maintained their response for 6 months on citalopram versus only 3 of 10 who discontinued the medication. Researchers suggest that maintenance of response indicates a true drug effect since no shopping logs were kept during the follow-up period.

Fluvoxamine (Luvox) was not found to be more effective than placebo in two earlier controlled studies (Journal of Clinical Psychopharmacology, 20:362-366, 2000 and Annals of Clinical Psychiatry, 12:205-211, 2000). These studies had high placebo responses that equaled the medication responses. It has been suggested that responses in these two studies and in open trials are due to the benefits of education and activities, such as, record-keeping diaries to increase awareness of compulsive shopping behaviors. The study above included a 6-month follow-up without education and shopping logs to better assess the effects of medication. (JHG)

When Reassurance is Harmful

(continued from page 1)

she called again, and again, and again until the hospital refused to take any further calls. When she couldn't get reassurance from the hospital, she turned to her husband. "Does the child look like us? Did you see any other Asian babies in the hospital? How can we be sure the blood tests and medical records prove we are the parents?" Realizing that his attempts to comfort her were futile, the father tried to ignore her. This only caused her to redouble her efforts; she followed him from room to room demanding that he answer her questions. Her demands became so frequent and intense that he eventually moved out of the house and rented an apartment of his own. At that point, the mother entered an intensive treatment program where they both received help.

Reassurance requests can become reassurance demands. This happens when the person threatens emotional outbursts or has temper tantrums if his demands are not met. The person may insist on hearing certain words, words said in a certain way, or repeated in a ritualized fashion. When this is not enough, he or she may demand that others actually perform rituals for the person. For example, I worked with a woman who was afraid that she was touching children inappropriately, touching them in a sexual way even though she was unaware of actually doing it. These fears would frequently occur whenever she was close to lots of children in public places. On the way home, she would question her spouse about any misdeed; and, once home, she worried that someone saw her touch a child and reported her to the police. From then on, sounds from the outside were interpreted as the police descending on her home and pounding on her door at any minute. Again she repeatedly sought confirmation that she wasn't about to be arrested. Also, she compulsively opened her apartment door and surveyed the street to see if the police had arrived. When she went to bed she had to routinely repeatedly check all the locks on all windows and doors. However, this wasn't enough. She would then ask her husband to assure that she had done the checking. When his reassurances eventually failed to comfort her, she then demanded that he repeat her checking routine.

As you can see, trying to satisfy demands for reassurance is like trying to fill a bottomless pit. Now, the second paradox: once reassurance elimination is underway, the reassured finds his desire for it vanishing until eventually he feels no need for it at all. There is also a corresponding decrease in the strength of his obsessions and other compulsions. But all of this is only realized after reassurance has stopped. How, then, should one respond to reassurance requests from an OCD sufferer?

First, the person and his significant others are educated about the harmful effects of reassurance. They are given the explanation that providing reassurance interferes with recovery from the disorder. It does so by blocking exposure to the fear, which is necessary for the elimination of fear. Remember, exposure is the key to successful treatment.

Second, the person is instructed to abstain from asking for reassurance. A reassurance-seeker's most frequent questions are identified and s/he is told not to ask these questions. Frequently, there are subtle, indirect ways that the person obtains reassurance. These may be unknown to the reassurers, but knowingly practiced by the reassuree. For example, one client I worked with would abruptly stop doing whatever she was doing, sit down and space out. Her husband learned that these behaviors signaled that she was caught up in obsessions; and unbeknownst to him, they became a nonverbal request for reassurance that he would immediately provide by telling her not to worry, that her fears were irrational, that it was only her OCD. So, in addition to attending to the obvious requests, subtle, indirect ones also need to be stopped. The statement "I love you" seems caring, but is it when stated by a person who has violent obsessions? Most likely not, if said repeatedly, because it commonly elicits the response "I love you too," which can be comforting to a person, guilt ridden by images and thoughts of stabbing the reassurer.

Third, it can be expected that some requests for reassurance will continue despite the person's efforts to abstain from them. Therefore, those providing reassurance need to work out expressions that are acceptable to the person for refusing to offer it. One way of doing this is to say: "I think you're asking for reassurance. Remember, reassurance is not helpful it's harmful. Therefore, I'm not going to answer." However, if this method does not result in the elimination of reassurance requests, it could be possible that the agreed upon statement itself has become reassuring or that the client believes that no harm can occur because the reassurer would warn him. In this case, the best way to prevent continued reassurance is for the parties to stop talking about OCD entirely.

Now this elimination of reassurance is to be restricted only to OCD fears. By all means, the comfort and support that are given for the realistic worries and concerns of life should continue in the reciprocal way that one finds among people who mutually care for each other. In the case of OCD, however, this comfort and support comes from the absence of harmful reassurances.

From the President: 2002 Research

Dear Friends,

We are in the midst of our Annual Research Fundraising Campaign. To give you an idea of how critical your donations are to achieving the Foundation's goal of effective treatments for everyone with OCD, I've decided to share with you the progress reports we've just received from our 2002 Research Award winners. Their reports, better than anything I can say, will show how much is being accomplished; but, more importantly, how much more has to be done before we have effective treatments for everyone with OCD.

Best regards,

Janet Emmerman
President
OCF Board of Directors

Cytochrome p450 2D6 Polymorphisms/Duplications and Serotonin Uptake Response in OCD: A Pilot Study

Stefanie A. Schwartz, Ph.D. and John L. Black, MD
Mayo Clinic

Over the first three months of our study period, we finalized procedural flow sheets and began identifying patients in the Mayo database who had been diagnosed with OCD. Our first set of 23 recruitment letters were mailed out and of the 10 patients who returned our letters, two were not interested in participating. We have begun phone-screening those who indicated interest in participating in the study.

Thus far, three have been ruled as ineligible to participate for a variety of reasons. A total of six eligible patients have completed all phases of the study. Of these six, four have been nonresponders and two have been responders.

No adverse events have been reported. We are in the process of screening the remaining eight patients who expressed interest in the study. We will be sending out another round of recruitment letters in the near future. At this point, we anticipate being able to enroll the expected 40 patients into the study by the end of the budget period.

The laboratory aspects of this project are proceeding well. The two PCR-based assays for detecting duplications for the CYP2D6 gene are working well. The microarray assay w\for detecting CYP p450 genes is also functioning well. As a matter of fact, we will be able to use the CYP2D6 assays clinically beginning in January, 2003. Phenotyping using the dextromethorphan metabolic assay has also been standardized using normals and is being used in this research.

Hoarding in the Elderly

Gail Steketee, Ph.D.
Boston University School of Social Work

Our project aims to expand an existing investigation of compulsive hoarding among elderly people by employing a standard interview with a larger sample of people over age 60 with and without hoarding problems. Toward this aim, we have completed the following tasks:

* As suggested by the review committee, we have modified the interview slightly to include additional questions regarding hoarding behavior and OCD symptoms among first degree relatives to address questions regarding possible genetic linkage for hoarding behavior.

* We obtained IRB approval to continue the project, to include the modification noted above, and to recruit new participants.

* We have hired a master's level clinical psychology student interviewer/research assistant and trained her to conduct interviews.

* Letters have been sent to all area social service agencies announcing the continuation of the project and providing information regarding our findings to date and emphasizing our need for more participants.

* Six interviews have been scheduled and four completed to date.

We believe the project is proceeding well during this first quarter and expect to increase the number of interviews in the coming months to meet our target goal of 50 to 60 people. We expect to present nearly completed data at the next OCF Conference in 2003.

Home-Based versus Office-Based Behavioral Treatment of Obsessive Compulsive Disorder

Martin Antony, Ph.D.
Anxiety Treatment and Research Centre
St. Joseph's Hospital

In the first few months since receiving funding for this project from the OCF, we have made progress in the following areas:

* Our ethics proposal was submitted for review at the beginning of June, 2002.

* We obtained final ethics approval on July 24, 2002.

* Two experienced therapists were hired on a contract basis; and two additional therapists who already work in the Anxiety Treatment and Research Centre have been identified as back-up therapists.

* A method for supervising the therapists has been developed and implemented.

* Three patients are currently in treatment in the study.

* Four additional patients have been assessed for the study and are scheduled to begin in November, after their medications have been stabilized.

* Two other patients were screened for the study, but failed to meet entry criteria.

* We intend to implement shortly a plan to increase enrollment.

The Effects of Cognitive Behavioral Treatment on Neurochemical Compounds in Patients with OCD: Evaluation of Proton Magnetic Resonance Spectroscopy

Stephen P. Whiteside, Ph.D.
Mayo Clinic

Over the first three months of our study period, we have developed the study protocol for screening, assessing, treating and scanning the participants. In addition, we have trained two therapists in the use of the treatment manual we have developed and have trained two independent evaluators in the use of the assessment measures. We have also developed and tested an imaging protocol with which we have successfully collected our target data from multiple pilot participants. Through multiple iterations of this protocol, we are now

Award Update

able to image the head of the caudate nucleus and the orbitofrontal cortex.

We are doing well with our subject recruitment. We have screened more than 15 patients for the study and currently have six potential participants in various phases of screening for eligibility. One patient completed the diagnostic interview and was not eligible because of the presence of exclusionary diagnoses. Two other patients have been successfully screened and are currently scheduled for the first appointment of the study where they will participate in a diagnostic interview and be enrolled in the study if appropriate. At this point, just four months into the study, we anticipate being able to enroll the expected 15 patients into the study by the end of the budget period.

Cognitive-Behavioral Therapy for Comorbid OCD and Major Depression

Jonathan S. Abramowitz, Ph.D.
Mayo Clinic

Over the first three months of our study period, we have developed the treatment manual, trained two therapists in the treatment protocol outlined in the manual and trained two independent evaluators in the use of the relevant assessment measures. A single pilot patient has been run through the treatment program and was treated by one of the study therapists. This patient, a 24-year-old male, evidenced a substantial reduction in depressive symptoms and a moderate, yet clinically significant, reduction in OCD symptoms. After the 16-session treatment, his BDI-II score was reduced from a 44 to a 21 while his YBOCS score was reduced from 31 to 15. He continues in therapy and we plan to submit a case report of this patient for publication this fall. The patient tolerated the protocol treatment well and subjectively found it to be beneficial. He also provided necessary feedback for modifications to the treatment manual. The information gleaned from this patient's progress and the therapist's experience with the treatment manual was fed back into manual revisions before the first study patient was enrolled in mid September.

We have screened 15 patients for the study and enrolled three patients in the study. Several were ineligible because they did not have OCD. One of these patients dropped out of treatment after the first assessment visit due to financial concerns. The second has completed four therapy sessions, and the third will begin therapy in the study in the next week. At this point we anticipate being able to enroll the expected 15 patients into the study by the end of the budget period.

The Effectiveness of Cognitive-Behavioral Treatment for Obsessive-Compulsive Disorder: Do Symptom-Based Subgroups Respond Differently?

John E. Calamari, Ph.D.
Anxiety and Obsessive-Compulsive Disorders Treatment and Research Program
Finch University of Health Sciences/The Chicago Medical School

We have completed the prerequisite study, "Obsessive-Compulsive Disorder Subtypes: An Attempted Replication and an Extension of a Symptom-Based Taxonomy."

As of this date, we have the following participants entered into our protocol: 111 in Pretreatment Assessment and 92 in Post-treatment Assessment.

We continue to pursue all participants who have reached the post-treatment for our 3-month, 6-month and one-year follow-up assessments. After extensive discussion, we have decided to include participants from the Rogers Memorial Hospital residential program in the protocol to significantly increase sample size and to take advantage of the opportunity to characterize the OCD of these individuals who typically have severe manifestations of the condition.

Our related subtype study is now complete and we intend to submit it for publication. We have identified two plausible subtyping taxonomies based on quantification of the clinical interview Yale-Brown Scale checklist, five-subgroup model and a seven-subgroup model. Although each model has several advantages, identification of the better taxonomy awaits completion of our treatment outcome work.

Support the OCF Research Fund

OCD, ERP & Me

(continued from page 4)

imagery that appeals to individuals will vary depending on their life experiences. I found two images to be appealing and reinforcing. In one, I see myself standing by the ocean's edge. Powerful surf beats up against me and knocks me over. I then decide to lie down along the shore. Now the surf just rolls over me. I am not knocked down as I was when standing up and offering resistance. In this image, standing represents the counterproductive resisting of obsessive thoughts; lying down represents the indifferent, more passive response to them that we are trying to achieve. In my second image, I am standing on a cliff, looking down at a flowing stream. All my obsessive thoughts are flowing by, but I am observing them in detachment, unconnected to them, and watching them pass away. If I find myself beginning to fight an obsessive thought in my daily life, I can bring these two images to mind to remind me to stop.

The role of spirituality in recovery can also be important. We should engage body, mind, and "soul" in the process. This is the hardest dimension to write about, however, because it is so personal and difficult even to define. Spirituality does not necessarily have to have anything to do with organized religion or even a belief in a conventional God. For me, it means my connectedness to everything beyond me (hence a way to be delivered from self-absorption); my most deeply-held though not necessarily provable convictions; and what empowers me and gives meaning to my life. I have tried to see my disorder not as some bizarre curse, but as part of the human finiteness and imperfection that, in one way or another, affect us all. An omniscient God, I remind myself, knows the difference between thoughts we want and thoughts we don't. The certainty and absolute assurances that we obsessionals seek are humanly unattainable; we have to commit to decisions we make in good faith and then "let go and let God." The Universe is essentially nurturing; we can make ourselves more open to its nurturing forces through prayer and meditation. These are the kinds of insights and convictions that, if we genuinely hold them, can be marshaled in our fight against OCD.

My own experience has made me an unabashed advocate of ERP. ERP requires persistence. Finding the right therapist and the right medication requires patience. I wish my fellow sufferers the persistence and patience that will lead to recovery.

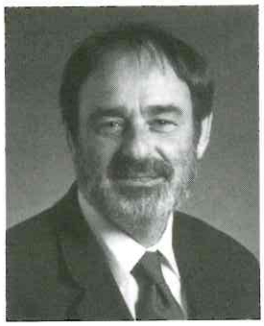
Robert J. Penella can be reached at rpenella@fordham.edu.

Genetic Research: Why Should We Participate

Interview with Dr. Gerald Nestadt regarding the goals of the OCD Collaborative Genetic Study and the value of participating in this important study.

NEWSLETTER: Dr. Nestadt, you are involved with investigators at six research sites in genetic research. What exactly are your groups investigating?

Dr. Nestadt: The goal of our research is to identify the genetic causes of OCD. This is a critical issue for understanding how OCD develops. To date we remain largely in the dark about understanding who will develop OCD and how this occurs. Learning which genes are involved will lead to a greater understanding of how the disorder develops, and ultimately the development of rational treatments. This knowledge will also enable us to identify individuals at risk for, or protected from, OCD, and hence will encourage the development of preventive strategies. It is likely that OCD is not a single condition and that identification of genes related to OCD may identify OCD subgroups that require different treatment strategies.



Dr. Gerald Nestadt

The academic centers participating in this NIH-funded collaborative research study are: Brown University (Drs. Ben Greenberg and Steven Rasmussen); Columbia University (Drs. Abby Fyer and James Knowles); Johns Hopkins University (Drs. Gerald Nestadt, Mark Riddle, Jack Samuels, Joe Bienvenu, and Marco Grados); Massachusetts General Hospital (Drs. Scott Rauch and Michael Jenike); National Institute of Mental Health (Dr. Dennis Murphy); and UCLA (Drs. Jim McCracken and John Piacentini).

NEWSLETTER: Are there genetic factors that may increase the susceptibility to OCD?

Dr. Nestadt: Family studies indicate that there is an increased risk of OCD in the relatives of individuals with the disorder. Twin studies have found a substantially higher rate of OCD in identical (monozygotic) twins than non-identical (dizygotic) twins. Statistical analyses investigating the mode of transmission of the condition suggest that genetic factors are involved in many families. However, specific genes have yet to be identified.

NEWSLETTER: What are the advances in molecular biology and statistical genetics that have opened the door to research on the genetics of OCD?

Dr. Nestadt: Genetic research has made enormous strides and continues to do so. The highly publicized Genome Project has identified the location of genes. Statistical methods have progressed considerably in determining associations between specific genes, or regions across chromosomes, and disorders. These developments greatly enhance our likelihood for success.

NEWLETTER: Are you and your colleagues looking for a specific gene that causes OCD?

Dr. Nestadt: The approach that we are taking is a systematic screening of the entire genome to identify susceptibility genes. This approach doesn't consider ***a priori*** any specific genes. However, as the project progresses, and as specific chromosomal regions that appear associated with OCD are identified, priority will be given to studying genes in those regions that are involved in biological pathways that seem to be OCD related. It must be remembered that OCD may have a "complex" pattern of inheritance; that is, more than a single gene, as well as environmental factors, may be involved.

NEWSLETTER: What can our members do to help these teams with their research?

Dr. Nestadt: Members who have two or more relatives with OCD (they don't need to be diagnosed or in treatment) should contact one of the six sites nearest to them (or, if at a distance from all sites, then Johns Hopkins or NIMH). They will be asked about all their family members. If the family is suitable for the study, arrangements will be made to interview family members. The interview takes 2-3 hours. A blood sample will also be drawn at that time. Each participant will receive $50 for his or her efforts. The information provided will remain entirely confidential.

NEWSLETTER: Is it important that eligible families participate in this research?

Dr. Nestadt: Families that participate will be providing an enormous service to ultimately help all people who suffer from OCD. It is critical that we have a sufficient number of families participating to conduct this research and many families are necessary.

My Children Have OCD

(continued from page 5)

life long process and I am grateful for the knowledge I have gained during this process.

One thing I have learned is that OCD comes in many forms. After Roman was admitted to the Obsessive-Compulsive Disorder Center at Rogers Memorial Hospital, I ordered some videos and pamphlets from the OC Foundation. This information also helped the school and me gain more knowledge of OCD.

This knowledge led me to understand that Roman was not the only one of my children to have OCD. While Roman was in intensive treatment, I began watching my daughter Haleigh, Roman's older sister, do her homework. I was concerned when I saw her repeatedly straightening her books and pens. I tested her when she left the room and was astonished at her reaction when I had moved just one of her pens. She tensed up when she discovered one of her pens out of place. Then seemed to relax after putting her pen back in place.

I observed her for a few days and mentally reviewed her history. I looked back at the anger she had occasionally, which I had assumed was stress from the divorce, and realized she was exhibiting many OCD symptoms that I had not recognized earlier. Pulling hair, superstitious rituals, rewriting and rereading, catastrophizing are just a few. I had her evaluated at Rogers and she was also diagnosed with OCD at the age of fourteen.

Haleigh has since undergone six weeks of intensive treatment and is on her way to understanding the disorder. Though she struggles at times, she is the other extreme...an overachiever. She has always studied hard and has done very well in school. Now she needs to learn that everything does not have to be perfect.

Haleigh and Roman are both in the Rogers Follow-Up Program and I am searching for a therapist close to home who will work with them as they mature and learn to live their lives as normally as possible.

I now pay very close attention to my two youngest children. I want to be sure I don't miss any signs of OCD they might exhibit. The therapist at Rogers remind me good naturedly not to "catastrophize" them or to find OCD where there isn't any. But if I see the signs, now I know I have great resources to turn to if I need them.

Dealing with OCD is a lifelong process, but it doesn't have to become your life. I am so grateful to all the people who have helped my children and me. The therapists at Rogers (Julie and Pauline – thank-you), the Kiel Area Public School System, and my family. For anyone who is dealing with a family member with any anxiety disorder, I hope you find support in the peo-

From the Foundation

(continued from page 1)

To my observation that whoever created Monk had more insight into OCD than anyone one could get just from viewing "AGAIG" or reading Judy Rapoport's "A Boy Who Couldn't Stop Washing," Mr. Breckman offered that everyone he knows has quirks. And, well, yes he had a little OCD. "I don't have anything that makes me dysfunctional. I haven't crossed that line. But, I've been known to check the front door more than once and sometimes to wash my hands a little too much."

He describes his personal situation as not enough to make him dysfunctional, but just enough to give him sympathy for Monk's situation and insight into how the obsessions and compulsions limit Monk's life but at the same time make him an incredibly acute observer. Breckman feels that this ability to really concentrate on details, to see what others disregard in any given situation, which is a product of Monk's OCD, is what makes him a brilliant detective. For example, in the series opener, Monk's observation of a kinked blind cord at the window from which the assassin fired, which all of the police detectives at the scene missed, tells him how tall the assassin is and where he learned his trade. The kinked-up cord also drives him into a realigning ritual.

In talking about how they developed their idea into a series, Breckman pointed out that the show is first and foremost a detective show, not a documentary about OCD. "After David came up with the idea of a detective with OCD," said Breckman, "we had to ask ourselves a lot of questions. How would the OCD manifest itself? It had to be obvious enough to create an obstacle that the hero would have to overcome, but not so debilitating that he could not function as a detective. We asked ourselves whether Monk would be a cop or a private detective. For every scenario and decision, we had to explore how the OCD would play out."

Breckman and Hoberman weren't "OCDish" in deciding on what compulsions and rituals Monk would have. "We had to give him symptoms that would make him uncomfortable and limit him. But the quirks/compulsions couldn't completely debilitate him. For instance, he couldn't have agoraphobia, because then he would never be able to go out and solve the mystery. We finally decided on germ phobia and orderliness."

Through the dialogue and flashbacks, we learn that Monk is a former San Francisco homicide detective who is on disability leave. His meltdown was caused by the murder of his wife to whom he was devoted. When the series starts, it's four years after his wife's death and the killer hasn't been found and Monk is haunted not only by his lost love but by his inability to solve the most important case of his life.

He desperately wants to get his job back, but he is still severely limited by his OCD. So, with the help of Sharona, played by Bitty Schram, his nurse, assistant, business manager and guardian angel, he is working as a private investigator, called in by his old department to solve all of their toughest cases. "Sharona," explained Breckman, "is Monk's Dr. Watson. She's his sounding board for testing his theories. She is pragmatic, no-nonsense, caring and daring. Her role is the device we use to help Monk overcome the obstacles OCD puts in the way of his solving cases. She also talks to Monk like my wife talks to me."

photo by Patricia Ballard

While we were talking, I asked Breckman if Monk was in love with Sharona. Like his creation, he didn't say yes or no right away. He talked to a conclusion he didn't know he was going to draw until he got there. The gist of it was: Well, he certainly needs her. Without her, he can't function as a detective. He does take her for granted because he is so dependent on her. But, he doesn't just depend on her to supply him with hand wipes; she is there to listen as he evolves his theories. Her pragmatic views and insights nudge him along. Their interaction definitely plays a big part in Monk solving the case. "Yeah," Breckman finally allows, "he adores her and is grateful and he can't live with out her. But having them fall in love on the series would be the second worse mistake I could make as the executive producer of this series."

While we were talking, I told Breckman that one of the many calls that we received at the Foundation after "Monk" premiered was from a therapist who treats OCD. He said he liked the program but was distressed with the portrayal of how Monk was being treated for his OCD. He said he felt that the writers should show him being treated with E&RP. "What's E&RP?" was Breckman's response. "Can it cure him? If it can, we won't be showing it. That would be an even bigger mistake than having him fall in love."

Breckman and Hoberman created "Monk" and wrote the pilot over three years ago, initially for a station other than USA, where it debuted on July 12, 2002. Now, the series is on both ABC and USA.

There are 11 shows already completed for the first season. Breckman and Hoberman and their staff, which now includes three full time writers and several free-lance writers, are already working on the 13 episodes for the second season. The group meets together for weeks, working out the plot for the entire season. "We have to weigh every plot twist and every mannerism we give a character from the point of view of the whole season because once you chose a ritual or a relationship, you're married to it for the whole series," Breckman explained. "Everyone has ideas and they're all aired. Then after the story is framed out, one writer goes off and drafts the actual script for a specific show."

The process of creating a television detective series is an exercise in problem solving, according to Breckman. "The first step is deciding on the crime and then we have to come up with a plausible way for Monk to solve it involving his OCD. This means we have to figure out how Monk's OCD would be impacted by a particular factual situation and then devise a way for him to surmount the obstacles his OCD presents all the while using his OCD as a way to solve the mystery." "By the way," he added, "we put Sharona in there to help him over these obstacle. She's the one allows him to move the plot along."

"So, if Monk isn't going to marry Sharona or enroll in an intensive behavioral treatment program or take any SSRI medication, what's in the future for Adrian Monk?" I asked Breckman. "Well, we are probably going to introduce you to his family, maybe his father or a brother. He probably won't get back on the police force, but he's going to continue to keep trying because he's a hero. And, that's what heroes do; they overcome things, like bad guys and OCD."

Ciao,

Patricia Ballard

Yale Clinical Neuroscience Research Unit: Back

An Interview with Dr. Vladimir Coric about the studies being done at the Yale Clinical Neuroscience Research Unit.

NEWSLETTER: The Yale Clinical Neuroscience Research Unit in New Haven was one of the first places to test medications for Obsessive Compulsive Disorder (OCD). You and your staff have just been approved for a new medication study. What medication will you be studying?

DR. CORIC: Our new study will examine the efficacy of a drug called Riluzole (Ritulek) in the treatment of OCD.

NEWSLETTER: This medication is being used to treat ALS (Lou Gerhig's Disease). Why do you think it might be effective on OCD?

DR. CORIC: Riluzole is a glutamate antagonist and although initially approved as a neuroprotective agent for patients with Lou Gehrig's Disease, Riluzole has been hypothesized to have therapeutic potential in disease states associated with glutamatergic hyperactivity.

Dr. Vladimir Coric

Glutamatergic hyperactivity is thought to contribute to the neural circuitry dysfunction underlying OCD. Neuroimaging studies have consistently identified increased blood flow, metabolism and brain activity in the cortico-striato-thalamic (CST) neural network of individuals with OCD. Within these brain areas, glutamate and GABA driven pathways are thought to be responsible for balancing neural tone. One model regarding the pathogenesis of OCD suggests that overactivity in the glutamatergic pathway results in a self-perpetuating neural circuit between brain regions that drives OCD symptoms.

Pioneering work by Baxter and his colleagues showed that treatment with serotonin reuptake inhibitor (SRI) medications as well as behavioral treatments reduced CST hyperactivity in patients with OCD (Baxter, Saxena). These studies suggested that normalization of CST activity might be a final common pathway for treatment.

Thus, we hypothesize that persistent OCD symptoms in individuals who have failed to respond to treatment with SRI medications may be the result of a failure to adequately dampen glutamatergic hyperactivity. Based on preclinical and neuroimaging studies, we believe that a drug that directly attenuates glutamatergic hyperactivity might be a safe and effective strategy in treating refractory OCD.

NEWSLETTER: Who would be a good candidate to participate in this study?

DR. CORIC: Individuals with a primary diagnosis of OCD who have not adequately responded to standard treatment with SRI medications are candidates for the study (this study defines failure to fully respond to prior treatment as a Y-BOCS score of greater than 16 despite at least 8 weeks of treatment with the maximum tolerable dose of an SRI medication).

NEWSLETTER: This study is for both inpatients and outpatients. What's the difference between the inpatient and outpatient programs? Why would someone choose or be assigned to either the inpatient or outpatient program?

DR. CORIC: Yes, the study is offered on both an inpatient and outpatient basis. Both programs involve augmenting the patient's current SRI medication with Riluzole. Outpatients must be available to come in for weekly ratings.

Participants will be enrolled as either outpatients or inpatients depending on their clinical condition. Additionally, participants who are willing to travel from other states to participate in the study will be offered the opportunity to receive inpatient care for ease of study participation.

NEWSLETTER: Can you describe the inpatient program? Are there therapy groups? Will the inpatients be involved in Exposure & Response Therapy?

DR. CORIC: Yale's CNRU is an inpatient psychiatric research unit committed to providing the link between cutting edge breakthroughs in basic science and clinical neuroscience. The CNRU is a locked, voluntary unit located on the third floor of the Connecticut Mental Health Center and houses, at most, twelve research participants at any given time. The unit cares for individuals who are voluntarily admitted to try new treatments for their illnesses and individuals admitted to the unit suffer from a variety of psychiatric illnesses.

Study participants will be expected to remain inpatient for the entire six weeks of the study; however, patients routinely leave the unit at least three times a day for outside breaks and passes as warranted by their clinical condition. Visitors are allowed during scheduled visitation hours and extended passes are available depending on the participant's clinical condition. The CNRU is a nonsmoking facility, but patients are allowed to go out on smoking breaks three times a day if requested.

All subject participants will receive an individualized behavioral treatment plan.

NEWSLETTER: What are the accommodations for an inpatient participant?

DR. CORIC: The inpatient unit has six patient rooms with at most two patients per room. Breakfast, lunch and dinner as well as snacks are served daily on the unit. There are two lounge areas for patients to read or watch television. Patients are encouraged to utilize the level system and walk/visit surrounding areas.

NEWSLETTER: What happens on the first day of the study? Is there an intake interview? A physical examination? Orientation class?

DR. CORIC: The first day of the study involves orienting the patient to the unit and discussing the study at length. Patients will be interviewed by research staff, nursing and their admitting physician. A physical examination, EKG and routine laboratory studies will be performed.

Between days 1-3, the study participant will complete various baseline ratings regarding their OCD symptoms as well as an assessment of any depressive and anxiety symptoms. An EEG will also be performed. All study participants will begin treatment with Riluzole on Day 4.

NEWSLETTER: Can you describe a typical inpatient day in the study?

Staff meeting on the Unit

DR. CORIC: A typical inpatient day begins with breakfast at 8:00 am followed by various morning and afternoon group meetings. Lunch is served at noon and dinner at

nto Researching a New Medication for OCD

5:00 pm. Throughout the day the patients also regularly meet with their primary clinician. Weekend schedules are more flexible, allowing for later morning awakenings, longer visiting hours and patient-oriented activities.

NEWSLETTER: How long is the drug study? Is that the same time period for both inpatient and outpatient participants?

DR. CORIC: Both the inpatient and outpatient studies are six weeks in duration.

NEWSLETTER: How is the program set up for outpatient participants? Do they receive individual therapy of any type while involved in the study? Are they given Exposure & Response Prevention Therapy?

Suzanne Wasylink and Dr. Coric discussing their study

DR. CORIC: Participants in the outpatient program must be seen at a minimum of once per week for ratings and individual therapy.

NEWSLETTER: How many visits would someone who is an outpatient participant have to make to the Unit during the trial? How long would these visits be?

DR. CORIC: At a minimum, outpatient participants will need to attend an initial screening interview, baseline ratings and diagnostic evaluation, two EEG sessions, and weekly ratings scales. Weekly symptom rating sessions will last approximately 2 hours and individual therapy sessions will last approximately one hour.

NEWSLETTER: What are the criteria for being admitted to the study?

DR. CORIC: Males or females with a primary diagnosis of OCD who have significant symptoms of OCD despite treatment with SRI medications are appropriate for the study.

NEWSLETTER: Who will be running the study with you? What is your background and theirs in treating OCD?

DR. CORIC: The CNRU and its staff have a long tradition of treating individuals with OCD as well as running previous OCD research protocols involving both pharmacologic and behavioral interventions. Suzanne Wasylink, RNC, Director of Nursing on the CNRU, is the OCD study coordinator and brings with her fifteen years of experience with OCD research at Yale. Additionally, Suzanne has completed is responsible for training our staff in rating OCD symptoms and coordinating individualized behavioral interventions. Dr. John Krystal, Deputy Chairman of the Yale Department of Psychiatry, is also available for consultation and mentorship. Dr. Krystal has previously participated in running OCD protocols on the unit and is a co-investigator in the Riluzole study. He has vast expertise in the areas of glutamatergic mechanisms underlying psychotic and mood disorders.

With regard to my own training, I completed four years of training in the Yale Psychiatry Residency Training Program and was a Chief Resident on the Anxiety Disorders Firm at the VA Connecticut Healthcare System. My interest and experience in treating individuals with OCD expanded when I took over the position as Inpatient Unit Chief of the CNRU and the pharmacologic treatment of OCD has become the primary focus of my clinical research.

NEWSLETTER: What type of drug is Riluzole? Why is it thought that it might be effective on OCD? Are there any published results on its efficacy and safety?

DR. CORIC: Riluzole is a member of the benzothiazole class of medications and is a potent antiglutamatergic agent. Since recent preclinical and neuroimaging studies have implicated glutamatergic hyperactivity in the pathogenesis of OCD, a medication that dampens glutamatergic activity may have therapeutic potential in the treatment of OCD.

There are currently no published studies examining the efficacy of Riluzole in the treatment of OCD. Riluzole is generally well tolerated and is an FDA approved drug for the treatment of Lou Gehrig's Disease. Adverse reactions secondary to treatment with Riluzole from other studies that occurred in more than 5% of patients included: asthenia (loss of strength and energy), nausea, increased liver function tests, and abdominal pain. Uncommon adverse reactions that occurred in less than 5% of patients were diarrhea, pneumonia, dizziness, vomiting, vertigo (a sensation that the environment is spinning), oral parasthesia (an unusual sensation in the mouth such as burning or prickling), anorexia (loss of appetite), and sleepiness. Liver function tests will be monitored closely over the study (at admission, week experience a worsening of liver function tests.

NEWSLETTER: The program is free. Does this include inpatient board and room as well as medication and therapy?

DR. CORIC: All study treatment while an inpatient on the CNRU is free of charge. This includes the costs of medications, therapy, meals and room/board.

NEWSLETTER: Your program is basically a research program, not a treatment program? Will you continue to treat patients who have shown no significant improvement after the six-week test? Will you offer alternative treatment and medication?

DR. CORIC: Patients who show no significant treatment after the six-week trial will be offered the opportunity to stay for a prolonged period for an alternative clinical treatment if appropriate.

NEWSLETTER: Will the CNRU be providing any kind of follow-up or aftercare?

DR. CORIC: There is currently no formal follow-up or aftercare once the study is complete. Study participants will be referred back to their primary treatment provider. The study team, with the participant's permission, will communicate with the primary provider regarding the participant's treatment response or lack of treatment response. We will also provide any treatment recommendations to the primary provider if requested.

NEWSLETTER: If a participant shows improvement with the use of Riluzole, will he be able to continue with the medication after the trial? Will it be provided free of charge?

DR. CORIC: If the participant demonstrates a treatment response, we will provide a prescription for a two-week supply of the medication and recommend to the participant's primary therapist that the Riluzole treatment be continued on an outpatient basis. Riluzole will not be provided free of charge after completion of the study; however, it may be covered under an individual's insurance policy as an off-label use of the medication.

NEWSLETTER: Are there any age limits on who can participate in the study?

DR. CORIC: Currently, we are enrolling participants between age 18 and 65.

NEWSLETTER: If someone is interested in taking part in this research, who should he contact and how?

DR. CORIC: Individuals interested in the

What to do When Your Child Has Obsessive-Compulsive Disorder: Strategies and Solutions

by Aureen Pinto Wagner, Ph.D.

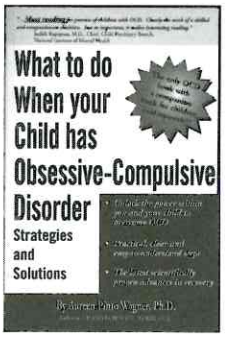
Reviewed by Lori J. Kasmen, Psy.D.
The Anxiety and Agoraphobia Treatment Center
Bala Cynwyd, PA

Reading Dr. Aureen Pinto Wagner's newest book, ***What To Do When Your Child Has Obsessive-Compulsive Disorder: Strategies and Solutions,*** is like having the opportunity to speak with a caring expert who patiently and generously shares knowledge based on scientific research and wisdom based on clinical experience. Although there are other books that cover the basics of childhood OCD, the clarity, compassion and sensitivity with which Dr. Pinto Wagner presents information make this comprehensive resource a must-read for parents, school personnel and professionals.

Throughout the book, Dr. Pinto Wagner's writing is to-the-point and jargon free, easily understood by the layperson. Numerous quotes and vignettes from affected children and their families will surely help those who do not live with the disorder understand its impact on daily life. Several tables including "Suggested Questions about Medications" and "Suggested Questions to Ask a Therapist" provide an invaluable quick reference guide. "Frequently Asked Questions" at the end of each chapter offer the reader further clarification of important topics.

The book is organized in two parts. Part I provides the "Essential Facts" about OCD including the steps to recognize, assess and get treatment for OCD. This part of the book may be particularly useful for parents whose children are newly diagnosed or in the early stages of treatment. Dr. Pinto Wagner provides a clear explanation of the difference between normal fears and OCD and outlines common obsessions and compulsions. She demystifies the evaluation and diagnostic process by walking parents through it step by step, offering solutions to potential hurdles that may arise as good treatment is sought.

In Chapter 5, Dr. Pinto Wagner eloquently explains the treatment of OCD, using her metaphor of the "Worry Hill" to outline the relationship among exposure/ritual prevention (E&RP), habituation and eventual mastery of OCD. In my experience, these metaphors are easily understood by parents, teens and even young children. The "Worry Hill" metaphor is elaborated upon with easy-to-remember mnemonics such as RIDE supporting their child during E&RP). This chapter alone makes the book worthwhile because an understanding of treatment is one of the important first steps toward recovery.



Part II of the book, entitled "What to Do," lays out the "Master Plan" for overcoming OCD. The author's humanity shines through in this section of the book because she recognizes the multiple challenges of coping with a difficult disorder amidst the busy reality of everyday life. She appropriately encourages families to simplify their lives and urges parents to take care of themselves so that they can most effectively cope with and lead the charge against OCD. Although parents are certainly the experts on their children, one concern underlying any treatment-oriented book is that parents will surrender their important role as mom or dad to take on the role of "therapist". Dr. Pinto Wagner addresses this delicate issue in her book by clearly explaining the importance of approaching the journey toward recovery with the help of a good clinician, outlining the necessary and unique roles of the therapist, the parents and the child.

One of the most significant sections in Part II is Chapter 9, which discusses a child's readiness for treatment. Ensuring that a child is adequately prepared and ready to tackle the challenge of the journey is an essential aspect of successful treatment; the importance of which cannot be overstated. Any parent wants a suffering child to get well as quickly as possible, but, as Dr. Pinto Wagner explains with clarity, beginning E&RP before a child is ready can have adverse effects. Other highlights of this chapter include child-friendly explanations of OCD and CBT and strategies to deal with the reluctant child.

After reading Dr. Pinto Wagner's book, I think many parents will feel as though they have had a face-to-face conversation with an expert, who patiently answered their questions and comprehensively addressed their concerns. Armed with this book, parents will have the knowledge to obtain good treatment and the sense of hope to

Funding Research

(continued from page 1)

we raised $168,050. In 2001, we raised $198,613. To date this year, we have only raised $162,417. In response to last year's letter, which went out to 15,000 people who have OCD or are family members, only 837 responded which is roughly 5% of you. When you think that OCD affects over 6 million people in the US alone, this still seems like a trivial amount. If we raised only one dollar per patient, we would 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 researchers around the world. Members of the OC Foundation's Scientific Advisory Board rank the proposals to be sure that the finest are funded. Last year we funded six projects. 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. In addition, this year there is a more pressing imperative as we now have a genetics consortium to fund. We have enlisted the world's finest researchers in the field of OCD genetics; and we need to make sure we have the funds to support this crucial work.

Many organizations have become major funders of high quality research. Organizations, such as, NARSAD, Tourette's Syndrome Association, and the Alzheimer's Association, individually raise many hundreds of thousands of dollars 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.

Once again, I know that this year in particular there are no shortage of 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
Professor of Psychiatry
Harvard Medical School
Chair, OC Foundation Scientific Advisory

Bulletin Board

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either ziprasidone or placebo (an inactive substance that provides no medical treatment) for 8 weeks. There will be a maximum of 8 visits in total. Each visit should last about an hour, except for the pre-study and final visits, which will last approximately 4 hours and will involve the following procedures: an extended interview by a psychiatrist to document your symptoms (every visit), a complete physical examination by a doctor of internal medicine, an EKG, and a blood sample will be drawn.

To be eligible, patients must be between the ages of 18 and 65, have OCD as their primary diagnosis, have obtained an unsatisfactory or no response from at least one, and up to three adequate SRI trials (Serotonin Reuptake Inhibitors: Anafranil, Effexor, Celexa, Luvox, Paxil, Prozac, and Zoloft), and agree to continue on their current SRI medication. Additional eligibility requirements will be reviewed with each patient during a detailed phone screen.

For more information, please contact:
Stanford University Medical Center
Department of Psychiatry/OCD
401 Quarry Road
Stanford, CA 94305-5721
Helen Chuong, Clinical Research Coordinator, (650) 498-5644
helenc@stanford.edu
Or visit our web site: http://ocd.stanford.edu

Cognitive Therapy for Obsessive-Compulsive Disorder

Massachusetts General Hospital is seeking participants with Obsessive-Compulsive Disorder (OCD) to take part in a research study. The purpose of the research study is to examine the effectiveness of cognitive therapy for OCD. Participants will receive:

- a clinical evaluation, at no cost
- 22 sessions of cognitive therapy, at no cost.

If you are at least 18 years of age and suffer from OCD, you might be eligible for this study. You must be able to attend weekly sessions in Boston. You may not receive any benefits from participating. It is possible that your OCD symptoms may improve from the cognitive therapy examined in this study. So far, there is some evidence that cognitive therapy may help individuals suffering from OCD, however, clinical testing is still investigational at this time. This study is being conducted by Sabine Wilhelm, Ph.D., and Gail Steketee, Ph.D. If you are interested in further information about this research, please contact Jeannie at the OCD Clinic at Massachusetts General Hospital at (617) 724-4354, or email jeannie@wjh.harvard.edu

Augmentation Strategies For Difficult to Treat Obsessive Compulsive Disorder

(continued from page 3)

because of sedation. In another study, low doses of clomipramine plus fluoxetine resulted in greater clinical improvement with fewer side effects when compared with clomipramine alone. Other antidepressants such as mirtazepam, nortriptyline, and imipramine are sometimes used.

Neuroleptics

Anti-psychotic agents (also referred to as 'neuroleptics') are not generally useful for patients with OCD. However, some small studies have shown that the addition of one of these medications to a serotonergic medication resulted in improvement in OCD in some patients who were treatment-resistant to the serotonergic agent alone. If neuroleptic addition is considered, it is important to identify specific 'target symptoms' that one is treating. If there is no improvement with the neuroleptic addition after a few months, the neuroleptic should be stopped because there is a risk of irreversible neurological side effects from these types of medications. OCD patients with tic symptoms may be more likely to respond to the addition of a neuroleptic.

In addition to several of the older 'first generation' anti-psychotic agents, over the last several years a few newer 'second generation' anti-psychotic medications have become available. The medical literature describes a few reports examining the effects of these second generation neuroleptics (Risperdal, Zyprexa, Seroquel, Geodon), suggesting that these medications may have potential utility as augmenting agents for some patients with OCD. One benefit of these newer anti-psychotic agents is the reduced risk of long-term neurological side effects. It is, however, important to be taking a SSRI prior to starting one of these drugs because they are known to worsen OCD or even bring it out when used alone. It is important to monitor weight gain with these drugs (especially Zyprexa) and to change medication if this becomes a clinically significant problem.

Depression Persists Despite Improvement In OCD

In patients whose OCD responds well to medication and CBT, but who remain depressed, the addition of a second drug to a SSRI may improve mood, often quickly and dramatically. In our experience, the most effective augmenter for this situation is Wellbutrin (bupropion), but other agents like lithium, Cytomel, pindolol, and the other antidepressants are sometimes effective.

Summary

As in patients with treatment-resistant depression, augmentation strategies, that is, adding another drug to the treatment regimen when the patient has had no or only a partial response to an initial drug, are worth trying. Prior to changing any antiobsessional medication, it may be useful to add augmenting agents for a two to eight-week period each. Based on case reports and clinical experience, this strategy will occasionally yield positive results. Clinical experience has shown that over 90% of patients with OCD improve with CBT and medication. Some patients, however, still fail to improve. The direction of future research will in part be focused on augmentation strategies. The following 'flow sheet' provides some treatment options and outlines where augmentation agents may be used. The order of using the primary serotonergic agents can be altered depending on the patient's need.

1. Sequential trials of serotonergic drugs for approximately three months each:
   - clomipramine trial - to 250 mg. per day
   - fluoxetine trial - to 80 mg. per day
   - sertraline trial - to 200 mg. per day
   - fluvoxamine trial - to 300 mg. per day
   - citalopram trial - to 60 mg. per day
   - paroxetine trial - to 60 mg. per day
2. Consider trials of Lexapro and Effexor
3. Consider augmentation of each of the above drugs prior to changing
4. Stop the above drugs for at least 5 weeks for Prozac or at least two weeks for the other drugs
5. Start monoamine oxidase inhibitor (MAOI) trial
6. Augment MAOI for one month (do not augment MAOI with buspirone, which can have severe and potentially fatal reactions)
7. Other medication trials - such as trazodone, mirtazepam, nortriptyline, imipramine, etc.
8. If severe personality disorder is present, consider half-way house placement or day treatment program
9. If patient is severely disabled despite adequate treatment trials, consider neurosurgical consultation in a specialized center
10. If poor compliance is a persistent problem, or patient prefers symptoms to being rid of them, or if the patient also has obsessive-compulsive personality disorder, consider concomitant psychodynamic psychotherapy

It is important to keep in mind that the most effective augmenting tactic is to add concomitant behavior therapy consisting of exposure and response prevention.

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