8th Annual Conference

OCD NEWSLETTER

Denver July 20-22, 2001

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From the Foundation

Dear Friends,

This is a very important season for the Foundation; on October 15 we announced our Call for Proposals. This is our solicitation of research proposals for funding. We picked October 15 because it is the date of our first Research Fundraiser.

Guests at Douglas and Joy Kant's home listen to Dr. Michael Jenike's talk on OCD research.

Joy and Douglas Kant of Newton, MA invited friends and family to their home for coffee and a talk by the Chairman of our Scientific Advisory Board , Michael Jenike, MD.

Their guests, the majority of whom are not personally affected by OCD, have been sending in contributions for our Research Fund. Thanks to the Kants and their friends the Foundation is going to be able to offer more research money in 2001 to inspire scientists to devote their energies to finding effective treatments for everyone with OCD.

We did an interview with Joy Kant after the party to learn how they put the fundraiser together. We'll run the interview in the next NEWSLETTER. It's our hope that other members will open their homes and hearts to support OCD research.

We also want to hear from members about fundraising ideas you have. Without continuing serious research we cannot hope to develop treatments for the sufferers for whom so far nothing has helped. This is a very large group and we cannot abandon them.

What would be really great is if we could build on the "Hoarders' Tag Sale" we sponsored in May of 1999. Affiliates and support groups around the country all staged a tag sale on the same day.

Here is Connecticut, we had a literature table and therapists who volunteered to talk with anyone who had a high score on the YBOCS tests we were asking people to take. Some of the other affiliates had face painters and games and sold raffle tickets.

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Researchers are Urged to Submit Proposals

Janet Emmerman, president of the OCF Board of Directors, recently issued a call for research proposals for 2001. In making the announcement that the OC Foundation is offering research awards, Emmerman stated that "The Foundation's research goal is to find 'Effective Treatment for Everyone.'"

"While the Foundation encourages any serious research related to OCD," noted Dr. Michael Jenike, chairman of the OCF Scientific Advisory Board and professor of Psychiatry at Harvard Medical School, "this year we want to see research into the brain. One way to find new treatments is to discover what is happening in the brain of someone with OCD."

The deadline for submitting applications is December 15, 2000. The Foundation has a new application form which can be obtained by calling Jeannette Cole at the Foundation (203.315.2190). "The new form," according to Emmerman who designed it, "is a hybrid of the NIMH form. It covers the same main points, but is shorter and infinitely less complicated."

"A subcommittee of the Foundation's Scientific Advisory Committee will review all of the proposals that are submitted," explained Emmerman, "and then make award recommendations to the Board of Directors. The winners will be announced in March 2001."

"At this point, we are still raising research money for the 2001 awards," stated Patricia Perkins-Doyle, Executive Director of the Foundation. "In 2000, we gave five awards which ranged in amount from $9,500 to $25,000. This year our goal is to do more."

For further information, contact Jeannette Cole. ◆

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

Setting Goals; Getting a New Life

In 1981 Jonathan Grayson and Gayle Frankel started G.O.A.L. (Giving Obsessive-Compulsives Another Lifestyle), one of the first support groups for OCD in the country. From that time on, the G.O.A.L. approach has been a powerful way for individuals suffering from OCD to help themselves. We thought we'd take this opportunity to talk to Dr. Grayson about the goals of G.O.A.L.

The Philadelphia G.O.A. L. Group at the Conference

What is a G.O.A.L. support group?
I think of G.O.A.L. as a support group plus. That is, like all support groups, members find the comfort and support that sharing a similar problem brings. However, there are times when unstructured support groups deteriorate into destructive complaint groups (or as one of our members refers to them: "pity parties"), in which members spend their time together comparing symptoms and medication side effects. G.O.A.L. goes beyond providing simple support and gives members a way to help one another.

So, how does a G.O.A.L. support group differ from a mutual support group?
The power of any support group comes first from mutual sharing among its members. We encourage members to support each other both during and between meetings. However, because we are proactive, that support is often in the form of encouraging the sufferer to gain some control over his/her OCD as opposed to simple commiseration.

What are the features of a G.O.A.L. support group that makes it effective with OCD?
I was wondering when you would get to that. We break our meetings into three parts: 1) the Question, 2) G.O.A.L. planning, and 3) socializing. These three parts are all necessary and each fulfills a very important function for every member.

First, there is the Question. Before each meeting, the leaders decide upon a topic to discuss; hopefully one that is of interest to everyone (e.g., how do you cope with uncertainty and how does this affect your OCD?). Remember, one purpose of a support group is to share ideas and thoughts about a common problem, and maybe, come away with new ways of looking at that problem. Without a Question, meetings tend to ramble and can easily become monopolized by a single individual's issues or again deteriorate into simply comparing symptoms and medication side effects. The Question provides members a stimulus for examining their situation from a different perspective, which helps them focus their ideas, thoughts and feelings about different aspects of OCD and its effects upon their lives - or in other words, a good Question leads to learning and growth. Of course, this depends upon the Question; sometimes we come up with great questions and other times not. We save the good ones.

Second is G.O.A.L. planning, the heart of the meeting, this is what keeps our meetings a place of hope and progress. Quite simply, members break into small groups, each led by a more experienced member, and choose behavioral goals to work on between meetings. Usually goals involve some form of exposure or response prevention. In this way, the focus of the group is always positive, reflecting our belief that everyone can help themselves and others to move forward.

Finally, there is informal socializing. The heart and power of a group resides in the friendship

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The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 11,000 members worldwide. Its mission is to increase research, treatment and the understanding of obsessive-compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to registered treatment providers; and the distribution of books, videos and other OCD-related materials through the OCF bookstore and other programs.

and trust people develop towards one another. Fighting OCD is hard work and having friends who can help is the defining feature of what makes a support group work. These kinds of relationships depend upon the sharing that best occurs outside of any structure beyond providing a place to gather.

How does a G.O.A.L. group help someone suffering from OCD? Does it have to follow your exact format?
Actually the G.O.A.L. concept is more flexible than you are suggesting. Our G.O.A.L. group is a support group. However, as I keep emphasizing providing support to one another needs to be more than words, providing support can and should be helping individuals to help one another. The idea of people empowering each other in a support group is not original with us. In AA meetings, the support is not simply people getting together, saying they have a biological problem and that their only hope is depending upon a higher power. They do this and encourage members to take very active steps in making life changes (e.g., taking responsibility for what each individual can control by supporting positive non- drinking behaviors and confronting one another when they engage in at risk behaviors). This is what G.O.A.L. encourages members to do with their OCD. On the other hand, the G.O.A.L. approach can be adapted to a variety of formats and could be incorporated into a programmatic behavioral group therapy program or into the Obsessive-Compulsives Anonymous format. G.O.A.L. is about empowerment and hope.

Isn't the concept of G.O.A.L. sort of intimidating for someone with OCD? I mean a sufferer meets with a group of strangers who are going to force him/her to do things his/her OCD has made impossible? How or why would anyone voluntarily submit to this?
The first rule of choosing a goal is choosing one you are willing to do, because we want the individual to be successful. It doesn't matter how small the goal is, because anything achieved is a start. If someone doesn't want to choose a goal at our meeting, that's fine. For such individuals, we believe that over time they will change, because they will see others coming to the meeting, making progress and enjoying the improvement in their lives. You ask why would anyone voluntarily submit to this and the answer is the desire to overcome OCD and the hope the comes with seeing the success of others.

Gayle Frankel, one of the originators of G.O.A.L.

You also write that the G.O.A.L. group has two purposes: to prevent relapse in people who have had Behavior Therapy and providing support for anyone with OCD. Those are two very lofty goals. How does the G.O.A.L. group format meet these "goals?"
Did I say two purposes? I should have said three, all growing out of the group's primary stated purpose, to help and support people in gaining some control over their OCD through the use of self chosen behavioral goals. The three goals are: 1) helping to prepare people for therapy who are afraid of CBT, 2) supporting CBT and 3) helping with relapse prevention. For those afraid of treatment, the meeting is a gentle introduction to behavior therapy and exposure, thus allowing them to experience coping with exposure and making progress. For those in the midst of a treatment program, the group encourages and supports the individual's efforts to persevere. Finally, for those who have overcome their OCD, the meeting's focus on goals makes it harder for the individual to pretend slips can be ignored, which could result in a small slip becoming a major relapse.

In your G.O.A.L. group Handbook you also refer to using support to prevent relapses. Can you elaborate what the connection is between relapse prevention and participation in a G.O.A.L. group?
OCD is both a learned and biological problem. With regard to the learned aspects, we know that for any long term behavior that a person tries to change, slips will occur. After all, how many people do you know who have gone on a diet, stopped drinking, stopped smoking, started exercising and so on and have never slipped. In addition, there are biological components in OCD and in some people these can rise and fall over time, making them more or less susceptible to relapse. The gist of what I'm saying is that slipping is inevitable. And if this meant being overwhelmed by OCD and again becoming dysfunctional, this knowledge would be devastating. But let me make this very clear, we aren't saying that. Again, think of a dieter who has lost 100 pounds and then gains 2 pounds. Do they want to do all that dieting for a mere unnoticeable 2 pounds? How about 5 pounds? 50 pounds? The problem is not in the slipping, but in how far you let it go. Do you "get back on the wagon" when "illegal" handwashing is 5 extra minutes a day or 5 hours? The good news is that either way, 5 minutes or 5 hours, you can recover; your behavior, like the example with dieting, just determines how hard you will have to work.

Now to answer your question, the G.O.A.L. support group can be used as a way to monitor yourself and make sure that you keep to your maintenance program and that if you slip, you know your friends will help you to not lie to yourself.

Does the G.O.A.L. group cure OCD? If not, why should someone be involved in it?
This goes back to your last question. One doesn't cure OCD. With treatment consisting of exposure and response prevention (ERP), often combined with medication, you can reach the point where OCD isn't interfering with your life. However, there will be slips to cope with. The group's goal is not to take the place of individual treatment for OCD, though we do have a small number of members who did use the group to structure their own ERP programs and recovered. So why should someone be involved? Often the support of fellow sufferers, people who know exactly how you feel, can be very helpful. On the other hand, we have seen less structured groups deteriorate into places of complaining,

G.O.A. L. continued on page 15.

Book Reviews

OBSESSIVE-COMPULSIVE DISORDERS: A COMPLETE GUIDE TO GETTING WELL AND STAYING WELL

By Fred Penzel, Ph.D.

Review
By Patricia Perrin, Ph.D.

Pat Perrin

Dr. Penzel's book is a comprehensive, scholarly, yet highly readable resource on treatment of obsessive-compulsive disorder (OCD) and its spectrum disorders, as well as a labor of love. Fred Penzel, Ph.D. is one of the most experienced psychologists and behavior therapists treating obsessive-compulsive spectrum disorders (OCSD's) today. Dr. Penzel chooses to focus on OCD and four disorders considered in the field to be part of the OCD spectrum, excluding others (e.g., Tourette's Disorder and hypochondriasis). He aims to reach as many sufferers of OCD, body dysmorphic disorder (BDD) (imagined ugliness), trichotillomania (TTM) (compulsive hair-pulling), compulsive skin picking, and nail biting as possible, with practical tools, in order to provide hope and a path to recovery.

Simultaneously, he provides the clinician a fly-on-the-wall view of how he treats OCSD's. He shares tried and true ways of communicating the rationale for treatment, how behavior therapy works, how to motivate individuals to undertake treatment, how to recognize the effectiveness of treatment, and how to prevent relapse. He comes up with gems, for example, in treating obsessions, "If you want to think about it less, think about it more,"; and in describing the effect of behavior therapy, when a real shift occurs, "It's like a spell has lifted."

Dr. Penzel uses the term OCSD's to refer to OCD and a group of disorders not currently classified together in traditional diagnostic schemes (i.e., the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition [DSM-IV]). This grouping is currently considered in the field to make sense, since these disorders share characteristics ranging from compulsive to impulsive. They also have similarities in their neurobiological etiology, and in their responsiveness to behavior therapy and, particularly, to serotonergic medications. Considering these disorders together should have implications for understanding and treatment of OCSD's.

Dr. Penzel describes how to implement two types of behavior therapy. Exposure and response prevention (E&RP) is used to treat OCD and BDD, and habit reversal training (HRT) is used for TTM, skin picking, and nail biting. Dr. Penzel's 18 years of experience are clearly demonstrated in his creative and plentiful examples of how to approach obsessions, compulsions, and impulsions. (He uses "impulsion" to refer to an urge or a call to action which seemingly cannot be ignored, and is acted on if it is gratifying, like grooming impulsions, but not acted on if it is repulsive, as in aggressive impulsions. Unlike compulsions, they do not serve to reduce anxiety.)

Fred Penzel

The longest chapter, on self-help, and the chapter on treating children are particularly useful in describing the specifics of implementing E&RP and HRT. Here the reader will be treated to detailed outlines of how to do E&RP for compulsions, obsessions, and impulsions, including examples of hierarchies of each and examples of specific exposures. HRT is detailed, starting with a preliminary step of destigmatizing oneself, followed by the traditional awareness training, breathing and relaxation training, competing response training, and a welcome section on augmenting HRT. The latter includes lists of suggestions specific to the different types of inputs that influence an individual's TTM, skin picking, or nail biting. Relapse prevention is addressed for all the disorders discussed.

The chapter on children will assist parents and clinicians with early identification of symptoms of OCSD's. Dr. Penzel alerts the reader to the role of Pediatric Autoimmune Neurological Disorders Associated with Streptococcal infections (PANDAS), which can trigger the onset of OCD and tic disorders. Finally, he tells how to tailor behavior therapies for children, e.g., by adding rewards to maintain motivation.

I have been reluctant to use the term "recovery" in discussing relapse prevention with patients, in order not to imply that OCSD's are addictions. Dr. Penzel's chapter on recovery and acceptance has prompted me to revise that position. He suggests that since it is rare that one's symptoms go away permanently, one must accept that "OCSD's are a potential you will always carry with you." Maintaining one's recovery, therefore, requires a) accepting what cannot be changed, e.g., having an OCSD, having setbacks, and experiencing anxiety, while b) changing what we can, e.g., doing exposures, blocking compulsions, using competing responses, increasing tolerance, and dispensing with perfectionism. He reminds therapists, who often become obsessed with change, that we must accept that not everything can be changed. Tweaking failed behavioral techniques alone may not be enough to succeed. Helping patients remove blocks to acceptance, e.g., perfectionism, overcontrol, and an excessive need for certainty, can completely shift the patient's awareness, and that may constitute the real change.

Dr. Penzel also includes in this book a thorough review of medication and alternative remedies, a chapter about family members, an entire chapter on obsessions, and one on compulsions. He also differentiates OCD from obsessive-compulsive personality disorder and discusses common disorders accompanying OCSD's. There is an outstanding chapter on the biological and environmental causes of and contributing factors to OCSD's. Finally, Dr. Penzel includes a list of helpful resources, evaluation instruments that can help in assessing OCSD's, and an 18-page glossary of terms. This book may seem excessively long, about 400 pages, but it doubles as an encyclopedia of OCSD's and a treatment guide. If you are a sufferer of OCSD's or a clinician, I believe you will find this book enlightening, uplifting, and potentially life changing. ◆

Book Reviews

FREEING YOUR CHILD FROM OBSESSIVE-COMPULSIVE DISORDER: A POWERFUL PROGRAM FOR PARENTS OF CHILDREN AND ADOLESCENTS

by Tamar E. Chansky, Ph.D.

Review By Bruce M. Hyman, Ph.D. and Cherry Pedrick, RN

With the publication of Dr. Tamar Chansky's new book, parents finally have a road map for helping their children deal with OCD. Dr. Chansky's experience as founder and director of the Children's Center for OCD and Anxiety shines through every page. Her book displays both a thorough understanding of OCD as well as deep compassion for the children and families afflicted by this disorder.

Part One defines OCD and reviews the diagnosis and treatment options. Dr. Chansky briefly discusses other disorders that sometimes coexist in children with OCD. "Chapter 2: Cracking the Code, Visualizing the Secret Mechanisms of OCD" is a valuable resource for anyone trying to understand OCD. Eight "lessons" explain how children - and adults - with OCD get stuck in a "brain trap" and how they can get unstuck. Each lesson is designed to help parents discuss OCD with their children in simple, creative word pictures.

Tamar Chansky

Part Two offers clear strategies to help parents fulfill their roles in the battle with OCD. Parents want to protect their children from pain and suffering while also fostering independence. This is especially challenging for parents of children with OCD. Dr. Chansky expertly guides parents along this difficult path. Chapter 10 discusses the importance of parents taking care of themselves. Powerful strategies are presented for dealing with feelings of anger, sadness, guilt, and shame, overcoming dysfunctional beliefs about OCD, finding outlets for feelings of isolation, dealing with stress, and knowing your limitations.

Part Three discusses the many forms of OCD. Dr. Chansky does not hold back - bad thoughts, worries about harm, scrupulosity, and sexuality thoughts are covered, as well as contamination, checking, repeating, redoing, evenness, ordering, symmetry, numbers, hoarding, and obsessive slowness. And what about brothers, sisters, grandparents, and other relatives? Chapter 15 helps parents decide when and how to involve others in the struggle with OCD. This chapter also helps parents decide how much to involve their child's school. Teachers will also find valuable insight here. The appendix provides lists of valuable resources and sample assessment instruments for OCD.

Throughout *Freeing Your Child from Obsessive-Compulsive Disorder* are quotes from children and parents that help the reader relate to the struggle with OCD. We would like to have seen more help for parents who also have OCD. This presents a particular challenge, but then, this could be the subject of another fine book. Tamar Chansky has produced a comprehensive resource no parent of a child with OCD should be without. ◆

FOUNDATION continued from page 1.

We can do that again. Or any number of other activities. How about a gift-wrapping night at a local mall during the holiday season or an OCD Shoppers' Night at a national chain store? That's where a store promises a certain percent of the sales on a night or day to a charity.

We are open to suggestions and pledge to give all the support we can to potentially successful fundraising activities members undertake.

As Dr. Jenike said in his Research Appeal Letter last year, there are lots of groups that are smaller than we are who have been able to raise significant money for research. United we can do the same thing. Write, fax or e-mail your ideas to me.

In this issue along with an eloquent plea for support from a father, we have recognized our members and friends who have made contributions to the Foundation since the beginning of 2000 through September 30. Thanks to all of them the Foundation has been able to publish this NEWSLETTER, maintain our award-winning web page, and provide referrals and information to the thousands of people who call looking for help each year as well as allowing the Foundation to sponsor its annual conference and behavior therapy institute.

We've also included a column on tax tips related to charitable giving as an added incentive.

My high school biology teacher used to say: "Repetition serves two purposes: to impress and to annoy." I hope I'm only doing the former when I say once more: Please give, if you can, so that we can find effective treatments for everyone." ◆

Patricia Perkins-Doyle

What Your Research Dollars are Doing

Robert M. Roth, Ph.D., of Darmouth-Hitchcock Medical Center, is one of the five winners of the 2000 OC Foundation Research Awards. The following is his most recent report on the progress he's made on his grant, Funtional MRI Activity and Inhibition in OCD.

Dear Grant Committee:

We have progressed in several directios including clinical aspects of the study, structural brain imaging, and fMRI task development.

On the clinical side, we have been working with colleagues in the Anxiety Disorders Service (ADS) at the Darthmouth-Hitchcock Medical Center to prepare media advertisements for the identification and recruitment of individuals with OCD in the community and identification of a primary clinician within the ADS to conduct diagnostic interviews.

We are developing a protocol for offering participants with OCD, as well as those identified with OCD but who declined to participate in the study, standardized cognitive-behavioral treatment within the ADS clinic.

In regard to the structural MRI aspects of the study, we have made progress in developing our detailed tracing manuals for obtaining the volumes of basal ganglia, thalamus, and frontal lobe subregions on MRI images and the modeling of subcortical structures.

We are presently finalizing the technical details of our MRI cognition activation task and will be obtaining pilot data from healthy volunteers in the near future. Then we will begin the patient studies. ◆

8th Annual Conference

Denver, Colorado

We have started to plan for next year's conference. We have the dates (July 20 - 22, 2001). We have the city (Denver, Colorado). We have the place (Downtown Denver Marriott Hotel). Now we need to decide which workshops and seminars to include, whether to have support groups and which types and how many and when? What activities should we plan for the children, the teenagers, the young adults? What do parents want to learn about and to whom do they want to talk?

WE NEED YOUR SUGGESTIONS!

So, fill out this form with your ideas for next year's conference and fax or mail them to the Foundation. Tell us who you want to hear, talking about what. Suggest activities that would be interesting, fun and affordable. If you don't know who you want to hear, but what you want to hear about, list that too.

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The Holidays are Coming

STOP AND SHOP AT GREATERGOOD.com

Shop for all of your end-of-the-year holiday gifts at GreaterGood.com. For whatever you need, GO to the OCD Website, HYPERLINK: www.ocfoundation.org

CLICK ON the OCF SHOPPING PLAZA and shop at the more than 80 retailers listed on the GREATERGOOD.COM SHOPPING MALL.

The OCF has become a partner of GreaterGood.com and will receive up to 15% of the sales price of items bought by shoppers who have registered the OC Foundation as their charity of choice. No, the 15% is not added onto the usual retail price of an item. This amount is donated by the merchants located at the the GreaterGood Shopping Mall. For what you would pay for an item ordinarily, you get the item and make a donation to the Foundation. This is definitely a win-win situation. But, it doesn't work unless you go to GREATER-GOOD and register the OCF as your charity of choice. So, shop until your fingers won't flex anymore.

RESEARCH —OUR LIFELINE TO A CURE —SUPPORT IT

Speaking for My Generation

Artwork by: Nolan Strais

By: Eric Weiss

Editors's note: Eric Weiss, editor and writer of Rumpshaker, writes this column for the OCD NEWSLETTER about the unique experience Generation Xers are having with OCD. We invite your letters and comments in response to his column.

The old cliche goes, "Knowing is half the battle." When it came to my OCD, no truer words had ever been spoken. Once I was finally diagnosed with OCD in college, I stopped feeling like I was "crazy" or "insane" but rather, I learned that I was dealing with a difficult, yet treatable disorder. My roommates still thought I was pretty damn crazy with all my lock checking, hand washing and obsessing, but hey, at least I had a rationale for it now! Knowing it was OCD that made me do these things made my life more bearable because I suddenly had reason for hope. Not being religious in any sense of the word, I wasn't able to turn to God to make things all better (though at my worst I did pray in a desperate attempt for relief...I found none). I also quickly realized that though friends and family tried desperately to understand, I knew they never could. Children (of any age) often look to their parents to help solve their problems. I grew up in a house where my mom always made everything all better. Try as she did to make things right, but to no avail...her son was still in agony. Friends and family could offer support and comfort, but no real healing. This is why a diagnosis of OCD was so important to me...it offered something no one around me could... a rational explanation to all of my irrational thoughts and behaviors.

But remember, knowing is only half the battle. Unfortunately, the other half of the battle is the really difficult part. Sure, it may be comforting to know that what you have is OCD, but the next question becomes...how the hell do I get rid of it? From what I understand, it's a question that many of us with OCD will be asking ourselves for the rest of our lives. I myself have made truly amazing strides in winning my battle against OCD, but even today I struggled with it. In fact, I spent a considerable amount of my afternoon today worrying about (introspection) some pretty dumb stuff. I doubt that I will ever be completely OCD free. Which I've come to accept. Because in all honesty, if my OCD never gets any better than it is right now, I will consider myself lucky, and I will consider my battle won. I look back on years of being afraid ALL the time, of not wanting to get out of bed because life was too scary to face, and I can't believe how far I've come (with a combination of behavioral therapy, medication and a lot of hard work).

When I first started to feel much better, it was like I was living again for the first time. I appreciated the mundane. I used to pick debris on the street up obsessively, thinking I had dropped illegal drugs. (Odd, since I've never used drugs in my life. And if I did drop them, why would I need to pick them back up if I didn't use them?) I also felt like I was somehow seriously injuring people who walked by me on the street, so I avoided it as much as possible. When I began to feel better, I realized just how great it feels to be able to walk around the streets without anxiety. Something that people do every day without a second thought became sheer pleasure for me. When my obsessions lifted, so did my spirits. I began to notice things like what a nice day it was outside. Or how bright the sun was. Corny, I know, but it illustrates just how far I came and how good I was (and still am) doing. So yeah, the battle may not officially be over, but I'm now certain that I'm winning. For those of you reading this who may not yet be doing as well in their battle, I'd like to assure you, I'm not writing this to gloat. But rather, I tell my success story to try to inspire.

Because if a "crazy" anxiety ridden guy like me can come this far, I'd bet anyone can. ◆

Thank you to our friends who have been so generous with their support.

Donations $1-$50

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Mr. Charles F. Williams	Livermore	CA
Ms. Debbie Zimlich	Louisville	KY

Dear Fellow Members:

As a parent, it is very important to me that there are effective treatments for everyone with OCD. My family was blessed. The physicians that helped us came up with a diagnosis and treatment plan that worked extremely well. So well, that the disorder is now a bad memory, not an everyday reality.

As everyone reading this NEWSLETTER well knows, this is not everybody's experience. The treatments available now—medication and behavior therapy—don't work for everyone. And, we don't know why they don't work or what will. This means that there are literally hundreds of thousands of people for whom OCD is their total existence. People for whom there is no effective treatment now.

More and better research is the only way to help these people. We need to get the best and the brightest minds available to find out why some sufferers are treatment-resistant. We need them to look for new medications, or different combinations of medications. We need them to tailor and fine-hone behavior therapy. We need them to look at genetics, environment, additional diagnoses and physiological differences.

It will take many people, time and money to get effective treatments for everybody. Lots of money to attract the best researchers, equip their labs, recruit participants, and develop workable treatments. But, we have these resources. We just need to use them. There are, according to the calculations Dr. Michael Jenike made in the Jan/Feb NEWSLETTER, between 6 million and 8 million people in the U.S. who suffer from OCD. That's more people than have breast cancer or AIDS or schizophrenia. So, there are definitely enough of us to raise the funds necessary to find effective treatments for everybody.

Even though our family no longer suffers from this disorder, I have never forgotten the constant pain and anguish from watching a child in despair. I vowed that I would do whatever I could to help those who suffer and their families. Each year I make the OCF Research Fund my primary charitable gift. I solicit my friends and business colleagues to give. And, they do. My hope and prayer is that we will soon find a way to end the torment.

Please make a donation to the OCF Research Fund now. Everyone can make a donation. The amount is not the issue. What counts is that every donation helps us to find a cure for those for whom we care. Ask your family, friends, co-workers or neighbors. You'll be surprised how eager they are to help. You only need to ask. It's not asking much when you consider that lives hang in the balance. And, as Dr. Jenike reminded everyone, all donations are tax-deductible.

Thank you for caring.

Thomas Lamberti, esq.

In the next issue, there will be a listing of individuals who donated to the Research Fund and those in whose honor or memory gifts were given.

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As we approach the end of the year, we encourage you to consider making a tax deductible gift to the O.C. Foundation.

Your gift may be made in a variety of ways and we will be happy to work with you to ensure that your gift is appropriately structured.

Some suggestions:

- A check to the O.C. Foundation dated and mailed on or before December 31, 2000 is a tax deduction for the year 2000.
- A credit card payment to the O.C. Foundation initiated on or before December 31, 2000 is a tax deduction for the year 2000.
- A gift of appreciated securities generates a tax deductible gift equal to the value of the securities.
- A gift in kind of material which the O.C. Foundation can use is tax deductible at its fair market value. At this time, the O.C. Foundation can utilize gifts of computer equipment and software. If you have other items that you are interested in donating, please contact the Executive Director.
- A gift of appreciated securities made to a charitable remainder trust before the end of the year will provide:

  an income stream to you (or a family member) for life, without reduction for capital gains tax;

  an ultimate gift to the O.C. Foundation; and

  an income tax deduction in the year 2000.

Your gift may be made directly to the O.C. Foundation, or it may be earmarked for research grants.

If you have any questions about year end gifts to the O.C. Foundation, contact the Executive Director at (203) 315-2190 or via email at pbp2325@yahoo.com.

Research Digest

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

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

ACQUIRED OBSESSIVE-COMPULSIVE DISORDER ASSOCIATED WITH BASAL GANGLIA LESIONS

Journal of Neuropsychiatry and Clinical Neurosciences, 12:269-272, 2000, R.C. Chacko, M.A. Corbin and R.G. Harper

Onset of OCD later in life, after age 40, is unusual. The authors report 5 cases of late-onset OCD, patients 61 to 77 years of age, associated with depressive symptoms and brain lesions. These cases support the view that if depressive symptoms are correlated with dysfunction of brain processing, basal ganglia lesions may further predispose depressed patients to the development of OCD. These cases also illustrate the need for careful workup of older patients with recently acquired OCD because their symptoms may be mistaken for delusional disorders, placing them at risk for misdiagnosis and antipsychotic side effects. In these cases improvement of the patients' fixed obsessions and their depression occurred with the use of selective serotonin reuptake inhibitors (SSRIs).

EFFECTIVENESS OF EXPOSURE AND RITUAL PREVENTION FOR OBSESSIVE-COMPULSIVE DISORDER: RANDOMIZED COMPARED WITH NON-RANDOMIZED SAMPLES

Journal of Counseling and Clinical Psychology, 68:594-602, 2000, M.E. Franklin, J.S. Abramowitz, M.J. Kozak et al.

The efficacy of behavior therapy (exposure and ritual prevention) for reducing symptoms of OCD has been demonstrated in several randomized controlled studies. Critics have argued that experimental control procedures used in these studies influence the treatment outcome and the results cannot be generalized to results that would be found in typical clinical practice. In this study the treatment outcome from 110 patients receiving behavior therapy on an outpatient fee-for-service basis were compared with the findings from four randomized controlled studies. Patients were not excluded because of treatment history, medications being taken, comorbid disorders, age or OCD severity. The OCD patients receiving outpatient behavior therapy achieved OCD and depressive symptom reductions comparable with those found in controlled trials. It appears that the encouraging findings for exposure and response prevention from controlled studies can also be achieved with "real" patients being seen outside research trials.

MUSCLE DYSMORPHIA IN MALE WEIGHTLIFTERS: A CASE-CONTROL STUDY

American Journal of Psychiatry, 157:1291-1296, 2000, R. Olivardia, H.G. Pope, Jr. and J.I. Hudson

Muscle dysmorphia is a form of body dysmorphic disorder in which individuals develop a preoccupation (obsessions) with their muscularity. The authors interviewed 24 men with muscle dysmorphia and 30 normal comparison weightlifters. The men with muscle dysmorphia differed significantly from the normal comparison weightlifters on numerous measures, including body dissatisfaction, eating attitudes, prevalence of steroid drug abuse and lifetime prevalence of mood, anxiety, and eating disorders. The men with muscle dysmorphia frequently described shame, embarrassment, and impairment of social and occupational functioning. Evidence also suggested that, like eating disorders, muscle dysmorphia may be stimulated by sociocultural influences. For example, the ideal male body image, as portrayed by the media, appears to have grown more muscular over the years.

OBSESSIVE-COMPULSIVE DISORDER WITH DELUSIONS

Psychopathology, 33:55-61, 2000, C. Fear, H. Sharp and D. Healy

This study examines cognitive (mental functioning) processes in patients with OCD, patients with delusional disorders and patients with both OCD and delusions. Delusions were more often found in subjects obsessional about one rather than multiple themes. There was also some support for proposals that depression and schizotypy may bring out delusions in OCD, in that patients with OCD and delusional disorder had more depressive symptoms, dysfunctional attitudes and magical ideation than either OCD or delusional disorder patients. In the present study, 80% of the pure OCD patients had multiple obsessions and 20% had single obsessions. Researchers support a classification of OCD on the basis of single or multiple themes, versus classifying OCD into specific symptoms such as 'washers' and 'checkers'.

AN OPEN-LABEL TRIAL OF ST. JOHN'S WORT (HYPERICUM PERFORATUM) IN OBSESSIVE-COMPULSIVE DISORDER

Journal of Clinical Psychiatry, 61:575-578, 2000, L.vH. Taylor and K.A. Kobak

Recent interest in and evidence for the efficacy of St. John's wort (Hypericum perforatum) for the treatment of mild-to-moderate depression has led to questions about its use to treat OCD. Twelve individuals with a primary diagnosis of OCD received a dose of 450 mg of 0.3% hypericin (psychoactive compound in St. John's wort) twice daily for 12 weeks. Results of this study found a significant improvement with St. John's wort, with a drop in Yale-Brown Obsessive Compulsive Scale scores similar to that found in clinical trials of selective serotonin reuptake inhibitors (SSRIs). The most common side effects reported were

I'm just checking to see if this burner is off.

diarrhea and restless sleep. The fact that a significant change was found in as early as one week of treatment suggests a possible initial placebo response, although improvement grew larger over time. The positive results of this study warrant further investigation of St. John's wort in OCD. Issues such as how to standardize herbal medications, contraindications, and drug interactions need to be examined as well.

THE RELATIONSHIP OF OBSESSIVE-COMPULSIVE DISORDER TO POSSIBLE SPECTRUM DISORDERS: RESULTS FROM A FAMILY STUDY

Biological Psychiatry, 48:287-293, 2000, O.J. Bienvenu, J.F. Samuels, M.A. Riddle et al.

The concept of an "obsessive-compulsive spectrum" of disorders is currently popular. These disorders are characterized as similar to OCD in terms of symptoms, presumed causes and response to treatments. This study investigated the occurrence of OC spectrum disorders in OCD patients, in control individuals without OCD and in first-degree relatives of the OCD patients and controls. Body dysmorphic disorder, hypochondriasis, eating disorders, nail biting, skin picking and trichotillomania occurred more frequently in individuals with OCD. With the exception of eating disorders, these disorders also occurred more frequently in relatives of individuals with OCD than in relatives of the controls. These findings indicate that somatoform (body dysmorphic disorder and hypochondriasis) and pathologic grooming conditions (trichotillomania, nail biting and skin picking) are part of the familial (inherited) OCD spectrum.

SERUM CHOLESTEROL IN PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER DURING TREATMENT WITH BEHAVIOR THERAPY AND SSRI OR PLACEBO

International Journal of Psychiatry in Medicine, 30:27-39, 2000, H. Peter, S. Tabrizian and I. Hand

There is evidence that serum cholesterol levels are elevated in panic disorder and generalized anxiety disorder. There are few data on cholesterol levels in patients with OCD. Thirty-three patients with OCD participated in this study. Serum cholesterol was measured at pretreatment and at the end of ten weeks. All patients received behavior therapy and either fluvoxamine (Luvox) or placebo. Cholesterol levels of OCD patients were higher than in the normal control subjects and comparable with cholesterol levels of patients with panic disorder. Secondly, the cholesterol levels decreased significantly with treatment of the OCD. Findings suggest that effective treatment, behavior therapy and/or a selective serotonin reuptake inhibitor (SSRI), may decrease cholesterol levels, especially in patients with high initial cholesterol levels. Researchers suggest caution in interpreting their results, as this is the first study investigating the influence of OCD treatments on cholesterol levels in OCD and the study design had several shortcomings.

A 6 MONTH DOUBLE-BLIND PARALLEL STUDY OF SERTRALINE AND FLUOXETINE TREATMENT OF OCD

International Journal of Neuropsychopharmacology, 3(Suppl 1):S240-241, 2000, A.V. Ravindran, R. Bergeron, V. Hadrava et al.

One hundred fifty adult OCD patients from 11 Canadian centers were randomized double-blind to either sertraline (Zoloft) or fluoxetine (Prozac) for 24 weeks. The study demonstrated that both sertraline and fluoxetine are effective and well tolerated in the long term treatment of OCD. There is some evidence suggesting that sertraline produced improvement at an earlier time point. ◆

MAKE A DIFFERENCE!
MAKE A DONATION!

You can make a difference in the lives of individuals with OCD. Make a donation to the OC Foundation or its Research Fund now.

WAYS TO MAKE A DIFFERENCE!
WAYS TO MAKE A DONATION!

Consider a lump sum of money, stocks or other assets. Name the OCF as beneficiary of your will, retirement annuity or life insurance policy. Give to the Foundation through your United Way plan. Encourage family members to do likewise. There could be a tax benefit in such gifts.

Contact your financial planner!
Contact the OC Foundation for Assistance!

When Seeing is Not Believing:

A Cognitive Therapeutic Differentiation Between Conceptualizing And Managing OCD

by Steven Phillipson, Ph.D.

Traditional CBT and OCD

Originating in the study of depression, traditional CBT presumes that all people possess irrational thoughts that have been shaped by society, family, and religion. These thoughts take on a life of their own, becoming automatic after years of unconscious repetition. The therapist's main tasks are to help clients examine these thoughts, determine their irrationality, and experiment with more rational and adaptive alternatives.

Traditional CBT derives power from facilitating awareness of self-defeating irrational thoughts. People suffering with OCD, however, require no assistance in this matter for they are already painfully aware of the senselessness and destructiveness of their thoughts. They often know that their compulsive washing is excessive and unwarranted by rational standards. Most OCD sufferers can even predict that the risk of danger is infinitesimal, yet they "feel" overwhelmingly compelled to act out some escape response.

Using traditional CBT techniques to treat OCD, the sequence of therapy might go something like this: activating event A = "The thought of killing my daughter while changing her diaper" occurred; automatic thought (belief) B = "This means I'm a horrible parent and may actually be putting my child at risk by being alone with her;" emotional reaction C = anxiety/guilt (for rational responses-see below).

The person would then ask: What evidence do I have that I would ever harm any child, let alone my own? They might conclude with a disputation D = "The chance of harming her is minimal." This cognitive restructuring may provide temporary relief. However, obsessions will inevitably focus on other elements of uncertainty that concern the person and will cause the anxiety to resurface. "Excuse me Doctor, all that makes sense but I did enjoy killing ants when I was a child and I heard a news report about a guy who went crazy and killed his children shortly after hearing voices telling him the world is coming to an end." Rational disputation also prevents the sufferer from an essential component of behavioral treatment- experiencing the fear! The explanation becomes a convenient escape hatch that perpetuates avoidance strategies.

Given all these weaknesses, traditional CBT may be counterproductive for the treatment of OCD. By failing to appreciate the actual experience and understanding of the OCD sufferer the treatment may also be detrimental, leading to feelings of frustration and alienation. For instance, an OCD sufferer might tell his/her therapist "You just don't understand! I already know how stupid and inefficient these repetitive thoughts and behaviors are, but they feel so real and threatening and I can't stop them!"

Traditional CBT misses the mark with OCD because it incompletely conceptualizes the nature and mechanisms of the disorder. The disabling condition of OCD results not merely from the presence of disabling irrational thoughts but more importantly due to the experience of an instinctual feeling of grave and imminent danger. Devoting a significant amount of time to explain the irrational nature of the thought content misses the underlying characteristics of the disorder. This is an anxiety disorder, not a thought disorder!

Cognitive Interventions: The "Thinking" and "Doing" Behind an Enlightened OCD Treatment

Analogizing the therapeutic challenge of OCD with that of a battle in wartime might prove a beneficial perspective toward understanding how to deal with this elusive condition more effectively. The two basic components of this battle entail the behind-the-scenes strategizing and the front line conflict. It is important not to confuse the appropriate application of these two separate strategies when managing OCD. The manner in which one conceptualizes a battle and the behavior exerted in fighting it are very different.

An innovative approach in Cognitive Therapy (CT) for OCD is the application of cognitive conceptualization (CC) and cognitive management (CM) to help the client to develop a therapeutically sound understanding and response to this unique disorder. Cognitive conceptualization focuses on removing the shame and guilt pervasive among OCD sufferers by providing a basic cognitive map of the hidden "rules" which OCD follows. Understanding the underlying dynamics enhances commitment to and engagement in the difficult and seemingly contradictory suggestions. Accessing the ideas and philosophy of cognitive-conceptualization in the midst of a challenge, however, tends to be reassurance oriented and consequently is ill-advised. The second part of treatment, cognitive-management is recommended to help people respond effectively to the cognitive prompt or physiological experience of the perceived danger in these more acute situations.

This is an anxiety disorder, not a thought disorder!

Cognitive Conceptualization(CC)

In stark contrast to psychodynamic therapists who attribute the origin of obsessions to deep-seated evil intentions, CB therapists work from the premise that people are not responsible for ideas that occur to them through automatic cognitive processes. Consistent with CB theory, surveys consistently show that approximately 90% of the population experiences violent and upsetting thoughts (the key difference between clinical and non-clinical samples referring to the subjective intensity of the thoughts and the different strategies used to cope with them). Many

of those who suffer from OCD, however, believe the psychodynamic premise, experiencing tremendous amounts of guilt not only for their unsavory thoughts but also for what it implies about their character. Therefore, helping people to separate themselves (i.e. their "genuine" identity) from the emotional and/or moral implications of what this disorder seems to represent is a major portion of cognitive conceptualization.

Neurological research seems to suggest that these automatic associations are produced by a part of the "emotional brain"(the amygdalla) activated when an organism prepares for emergencies. Brain mapping studies further indicate that the amygdalla is most active when OCD sufferers are confronted with feared stressors. In other words, there is no reflection on one's character for having a brain which produces these thoughts. With this in mind, it may be comforting (not therapeutic) to know that the content of one's obsessions does not characterize one's true identity. For instance, the spike "Oh my God, I may be gay," is only meaningful because of its accompanying anxiety. It does not imply that the person is actually homophobic or having a sexual orientation crisis. [Do not use this information in response to a spike as this will serve as a reassurance].

When one gives in to a ritual, the brain's sensitivity to the perceived threat is increased. Understanding that giving in to a ritual can have negative consequences is instrumental in fostering a sense of determination in the avoidance of relief-seeking behaviors. On the other hand, gaining insight into this treatment rationale does very little in regard to responding more effectively to the experience of imminent jeopardy. This is particularly true when the intensity is high and the threat feels very real. The amygdala is not a thinking part of the brain! It only transmits experience and therefore cognitive learning has no effect on it. No matter how many times a person learns that AIDS is not likely to be transmitted by doorknobs, the anxiety caused by the perception of threat can only be reduced by taking on the potential risk through contradictory repetitive acts(i.e. repeatedly touching public doorknobs and refraining from washing).

Cognitive conceptualization also involves empowering clients by helping them discover their ability to make their own choices. For example, such a choice could involve differentiating between surrendering to a ritual or embracing the risk of the obsession. "I CHOSE to wash my hands because the doorknob might have had AIDS on it, therefore, I was not willing to live with that possibility!" This statement contrasts with the belief that performing rituals in the face of threat is obligatory. It is common for people to experience a diminution in the urgency to perform a ritual once they acknowledge their willing collaboration and make the active choice to accept the distress. Studies measuring pain tolerance have shown that our ability to endure pain is greatly increased after we realize that we have the power to decide whether we wish to seek relief or withstand the discomfort. In the initial phases of therapy, however, statements such as, "I HAD to wash because I COULDN'T stand the anxiety," are frequently heard. These statements distance the person from more adaptive options and plunge them further into pessimistic thinking (i.e. that anxiety is inevitable).

The basic foundation for managing OCD rests on two basic behavioral concepts: extinction and habituation.

It is essential that one's method of generating cognitive responses not be pre-programmed, rote, reflexive reactions. The more one infuses a genuine emotional emphasis into the responses, the more they will enhance the potency and efficacy of the therapy. "There may be AIDS on the doorknob. I'll choose to TAKE THE RISK and touch it anyway." By deliberately creating the thought the person has the opportunity to really "get into it." Being purposefully emphatic about the nature of the upsetting thought contributes to greater levels of habituation.

As a result of yielding to the urge to ritualize many people feel a tremendous amount of guilt and regard themselves as being emotionally weak. It is critical to understand that relief-seeking is actually a biologically programmed response characteristic of human beings. It is instinctive to look for a solution to a dangerous situation when the anxiety center (amygdalla) of the brain is activated. The therapeutic response flies in the face of an overwhelming urge to obtain comfort. The therapy requires a diametrically opposite response. In an apparent emergency, the therapeutic option is represented by the door labeled DO NOT ENTER. The door labeled EMERGENCY EXIT is of course the one that gets you deeper into the quagmire. While encountering a highly charged feeling of jeopardy in the moment in which the bullets are flying, making the choice not to give in to relief-seeking requires a leap of faith toward these principles.

Engaging in the therapeutic guidelines is actually a very brave act. Few people make the effort to give themselves credit for touching a doorknob or accepting the possibility that they may be of harm to their own children. The reason to praise yourself for these acts of courage is that it would be tantamount for the non-OCD sufferer to be asked to lie down on train tracks and experience the feeling of being in danger without getting up.

Cognitive Management (CM)

The basic foundation for managing OCD rests on two basic behavioral concepts: extinction and habituation. Extinction is the process whereby variables that reinforce the repetition of a behavior are removed. In English this means that behaviors or thoughts tend to abate or even stop occurring when we take away the rewards for their ongoing nature. An example would be ignoring a child during a tantrum. By not consistently giving in to the child's demands, the tendency for the child to throw tantrums will decrease. In a behavioral treatment for OCD, not washing one's hands after touching the floor repeatedly will reduce the brain's sensitivity to the dirtiness of the floor. By consistently not seeking an answer to the question, "Am I a danger to my own child if I touch him without washing my hands?," eventually the brain will reduce its need for resolution.

Habituation is the biological tendency for the brain not to focus on information that is continually present. For example, individuals who live close to a train track tend not to be aware of the passing train's presence until a visiting friend mentions the surprising loudness of the passing train's sound. Habituation is represented in behavioral treatment for OCD by purposefully repeating in one's head

WHEN SEEING continued on page 14.

WHEN SEEING continued from page 13.
the nature of the spike, which consequently reduces the brain's sensitivity to its emotional intensity. Touching the bottom of your shoe and reminding yourself every five seconds of all the diseases you are going to catch and spread gets tiresome and old after five minutes of continual repetition.

Combining the principles of extinction and habituation led to the definitive non-medical treatments for anxiety in general and OCD in particular: Exposure and Response Prevention. The general guidelines of this procedure involve having people purposefully expose themselves to stressors without engaging in a ritual. These exposure exercises may entail having the client rub his hands on a sidewalk and not washing, or purposely creating the thought, "God is an asshole!" and then not praying for forgiveness. By purposefully choosing to come in contact with items or thoughts that are anxiety provoking, the brain tends to send back a less intense signal of fear because it habituates to the anxiety of the stressor. Because the person also chooses not to negatively reinforce the behavior or thought (by either avoiding the object or trying to reassure oneself of the thought's invalidity), extinction occurs.

"It's the end of the world as we know it and I feel fine!"

A second and almost equally important aspect of the treatment involves not giving in to the obsession inadvertently. Rather than just saying "NO! I won't give in," it is advisable to allow for the possibility that there is an actual risk. Choosing to accept the risk by eliciting physical discomfort and cognitive warning shuts down the brain's natural tendency to warn its host that he or she should feel horrible until the danger is removed. The cognitive element of therapy (i.e., purposeful mental statements about the possibility of risk) facilitates the impact of the exposure exercise, producing more resilience to relapse. With the statement, "Stay away from knives as you might be a risk to others," the exposure exercise would entail having the client purposefully grab a knife and even taking it to bed saying, "Tonight I make sushi out of my husband...I hope I have enough rice to go with it." Humor counts! The more you laugh at the OCD, the more disrespect you give it, the less power it has!

Seeking out the risks on purpose (i.e. rubbing one's hands on the floor and then eating a sandwich or creating the thought of jumping in front of an oncoming train), armed with the disposition of "come and get me," is by far the greatest facilitator of daily therapeutic gains! Without a doubt, the more aggressive one is in confronting the disorder, the less distress it will cause. Thus, as we turn the tide of the condition's momentum from endless escape to approach, we aggressively seek challenges and decrease the likelihood of finding them.

Cognitive-management also involves facilitating greater levels of tolerance toward anxiety by making space for the discomfort and viewing it as something to be managed effectively. It is important that one truly experiences and genuinely accepts the initial surge in anxiety, allowing it to occur naturally and spontaneously. To facilitate this process, often clients are instructed to rate anxiety levels (1-10 scale), describe the physical symptoms (e.g.rapid heart rate), assess the willingness to allow the anxiety to be there, and to determine a feasible time duration for the anxiety. By engaging in this process one rises above the experience, creating a more manageable distance and less discomfort. Paradoxically, the chances of obtaining relief are increased the less one seeks it out.

Without a doubt, the more aggressive one is in confronting the disorder, the less distress it will cause.

Cognitive-management also focuses on the importance of one's disposition while engaging in exposure exercises. You are on the front line of a battle and bullets are flying. What do you do? (Hint: Put away the training manual). For the purposes of our battle with OCD it is generally a good idea to respond in such a way that there is little to no "conflict or mental chafing" in response to being spiked. The main objective is to reduce/eliminate the fruitless efforts of mentally escaping the threat, in formulating a response to the upsetting thought. When your brain sees that you are no longer running from the feared topics, a long-term consequence is that it will generally not bother transmitting the warning (i.e. extinction).

"Within The Question Lies The Answer"

Given that intrusive thoughts are prevalent amongst the clinical and non-clinical population alike, it would be unreasonable to have OCD sufferers strive for their absence. Ultimately the goal of CBT is to manage the spike effectively not to extinguish it completely or to focus on its existence. Relief seeking promotes vigilance to one's anxiety whereas tolerance fosters disinterest. Making room for fear's presence allows the brain to focus on other information. Due to a lack of reinforcement, the anxiety burns itself out. Put another way, the less one toils with the bully the greater the likelihood that the bully will find someone else to pick on.

Often clients will state that the intensity of their anxiety makes it difficult to discern the legitimacy of the threat. "It feels so real!" is the calling card that seduces the person to give in to the ritual. Clearly, reassurances are of no value in dispelling an OCD sufferer's concerns. Many OCD sufferer's have found the premise "Within the question, lies the answer" a powerful guideline that helps them make a choice toward "risk taking" when the nature of one's spike leaves "any doubt" about its legitimacy. Focusing on the awareness that there is doubt (i.e., "Am I really in danger?"), then making the determination to accept the risk (i.e., "Maybe I am in danger, but I'm going to accept the risk and not undo the danger."), will eliminate a tremendous amount of maladaptive problem solving.

To those who are considering embarking on the difficult process of CBT for OCD, it is strongly suggested that therapy not be taken in small doses. Looking for a quick fix is not a winning formula. Taking responsibility for this life-destroying condition is paramount. Jump in and don't look back! (A variety of success stories by former OCD clients provide a general model for the positive mental framework outlined in this article and can be found on the internet at www.OCDonline.com.) ◆

G.O.A.L. continued from page 3.

hopelessness and comparing medication side effects. Because of the G.O.A.L. planning that takes place at every meeting, every meeting reinforces our belief that having OCD is not a sentence of endless misery and hopelessness; that steps can be taken to rediscover and reclaim one's freedom.

Why do you exclude families from G.O.A.L. meetings?

Family involvement can be a very important part of recovery and, obviously, people could choose to run a G.O.A.L. group with family and friends present. However, as I mentioned above, one of our most important rules for choosing a goal is the individual choosing something s/he is willing to do - not something to try, but something to be done. And choosing nothing is one of the options. Although some families can be very supportive and helpful, there are two situations in which their presence could inhibit or interfere. The first and most obvious is when the family is not supportive. The second is one in which the sufferer is resisting change, whether due to fear or other reasons. In either case, families observing those who are working hard might put additional pressure on the individual who is having difficulty at home. There are many circumstances in which I, as a therapist, might want this to happen. Indeed, family members may hear such advice in the family meeting that takes place simultaneously with our meeting. However, our meetings are for support, not therapy, and if the meeting attended by the sufferer results in greater pressure at home, then s/he won't want to return.

What and who does someone need to start a G.O.A.L. support group? If a person with OCD came to you and said s/he wanted to set up a G.O.A.L. group what would you tell him/her were the essential things s/he needed to do and have?

Patience and a willingness to put in a lot of time. The most difficult time for a group is the beginning, getting enough members to make the group work and getting enough publicity to attract new members. Making yourselves known to the local media and public service announcements may be necessary.

What keeps a G.O.A.L. group together? Your group has been running for almost 20 years, what has made the groups so cohesive?

The original group was started by Gayle Frankel (one of the current co-presidents of the Philadelphia Affiliate of the OCF) and myself. Along with Gayle and myself are a core of people (AnnaMae, Minette, Jene, Alan, Theresa, Linda, Ed, Pam, Donna and forgive me for missing anyone), who are dedicated to keeping the group going. Their reasons vary. For all of them, having conquered the hell of OCD has left them with the desire to help others out of the trap. In addition they use the group for maintenance, they know small slips will be confronted before they can become large ones.

Dr. Grayson, G.O.A.L. Guru

Who runs the G.O.A.L. meetings and how are they organized?

Our meetings are therapist assisted. This means that I and some of my staff volunteer our time to be present at every meeting, but we don't run the meetings. We leave that to our more experienced members and just jump in when the need arises. I think this is the ideal, sufferers running the meeting with a professional available. But there are times this isn't possible. If a professional is starting a G.O.A.L. support group, it will take some time for members to be experienced enough to take over. On the other hand, there are many areas where there are no professionals experienced with OCD; we hope that the manual we wrote would enable sufferers to run their own meetings.

Does a G.O.A.L. group always have to be professionally assisted?

As if I get to make the rules - it doesn't have to be run the way I think. The answer is it does not have to be. In our original conception, we were concerned with people in need of treatment where adequate treatment wasn't available. Our efforts were to come up with a support format that could provide some symptom relief, in addition to comfort.

A professional can be helpful in coping with some of the issues that arise; for example, helping leaders cope with a member who is monopolizing the meeting or going off topic, helping a very distressed member, or answering questions that s/he may be in a better position to know. But again, a professional does not have to be present. What I do think is necessary, is for the leaders, whoever they may be, to have an understanding of OCD that they can impart to newcomers.

How do you keep the group structured?

This falls upon the leaders of the meeting and their willingness to gently, but assertively keep straying members on track. This is not always easy and sometimes is the place a professional can be most helpful.

Should anyone who wants to start a G.O.A.L. group buy your video and handbook being sold by the OC Foundation? Why?

I think the package is very helpful for anyone interested in running a G.O.A.L. group. And this is not self-serving on my part - all profits from this package go to the OC Foundation. There are two parts to running a successful G.O.A.L. group: the vision of the group and the structure. The vision is critically important, this refers to what everyone in the group understands about the nature of OCD and its treatment. It isn't sufficient for such an explanation to be right and scientific. This is important, but understanding OCD (or any problem) requires an explanation that makes sense emotionally as well as logically. We believe that the first part of the manual gives potential leaders the information and tools to understand and explain OCD to themselves and others. With this achieved, the purpose and structure of the group described in the second part of the manual becomes possible.

What should a group do if it runs into a problem?

I can be contacted by e- mail (drjg17@hotmail.com) and as long as people can give me time to respond, I'd be happy to see if I could help. If enough people show interest, we will find a way to start an Internet G.O.A.L. group as a place for people to work on goals and for G.O.A.L. groups to receive support for issues that arise in group. ◆

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