

Cognitive Therapy For OCD: What It Is, When To Use It and When Not!

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Although cognitive therapy has been available for more than 20 years, only in the past seven years has there been exploration into the benefit of cognitive therapy in the treatment of Obsessive-Compulsive Disorder. So what is cognitive therapy (CT)? Several basic principles offer an understanding of the foundation of CT. First is the premise that thoughts and feelings are closely connected; thoughts influence feelings. Second, changing your thoughts can contribute to changing your feelings or mood. This includes feelings, such as, fear and anxiety often associated with OCD; but can also apply to feelings, such as, anger, guilt, depression, etc. Third, while you can't always change a sit-

uation or control an OCD triggering event (nor is this always clinically advisable when treating OCD), you can change the way you think about an event and in this way facilitate a reduction in your distress level. CT offers options for developing a new internal dialogue in response to emotion-triggering situations or thoughts.

The first step in CT is to increase your awareness of patterns of unproductive thinking. The following five cognitive domains are a compilation of some of the unproductive thinking patterns elaborated more extensively by Steketee and Frost (2002) and Burns (1989). As you read through, consider whether these patterns apply to the way in which OCD biases your thinking.

1) *Overimportance of thoughts.* Does the OCD influence you to put too much

(continued on page 10)

From The Foundation

Dear Friends,

I don't know about anyone else, but I had a really good time at our Tenth Annual OCF Conference. While I was hyperalert until I fell asleep on the dais when I was supposed to be taking notes at the Town Meeting for Dr. Jenike, I was not overwhelmed, overwrought or out-of-control at any time over the five days we were in Nashville. At least that's what it says on my Evaluation Form. We got there on Wednesday because someone had to take responsibility for making sure there were extra paper towels in the restrooms. That's not the type of task an OCD person can leave to maintenance professionals.

Jeannette, Daisy, Leslie and Mary had planned the Conference so well that even I ended up where I was supposed to be, when I was supposed to be there, with a bare minimum of fussing. They had prepared a minute-by-minute script that all I had to do was follow. The only problem was that it said I was to be at the Registration Desk at 5 am on Friday. I figured that was a typo and showed up around 9 am. At that point, Jeannette spent a little time with me in our "War Room" explaining her "strict adherence" policy and everything went off alright from then on 'til Sunday and the narcolepsy incident at the Town Meeting.

And, that other little problem, the one with the video tape of "Worried Sick," an exploration of OCD through interviews with sufferers by Terry Spencer Hesser. Somehow it was still on my desk in Connecticut when it was supposed to be in

(continued on page 11)

Does This Medication Make Me Look Fat?

The following is an interview with Eda Gorbis, Ph.D. of the Westwood Institute for Anxiety Disorders, Inc., who is also an assistant clinical professor at UCLA School of Medicine. In it, Dr. Gorbis discusses weight gain caused by the medications used to treat OCD and how to control it.

NEWSLETTER: Is weight gain an unavoidable side effect of the medications used to treat OCD? Why?

GORBIS: OCD is mostly treated with SSRIs. Usually, in complicated cases a combination of medications is used. Oftentimes, SSRIs are used in combination with antipsychotic medications. One of the undesirable effects of SSRIs is weight gain. However, some SSRIs are likely to cause more weight gain than others.

Medications usually have sedative effects which lead to an increased amount of sleep and a decreased amount of activity. Therefore, fewer calories are burned, which in turn leads to weight gain.

NEWSLETTER: Which medications used to treat OCD cause weight gain?

GORBIS: SSRIs are more likely to cause weight gain than other antidepressants. One study compared the effects of Prozac, Paxil and Zoloft. Results showed that Paxil caused more weight gain than Prozac and Zoloft. Paxil causes up to 25% more weight gain. Other studies have shown minimal or no weight gain with Celexa. More complicated OCD cases will not improve with SSRIs, so other drugs need to be added to augment the response. Drugs that are sometimes added include: olanzapine (Zyprexa), risperidone (Risperdal), quietapine (Seroquel), and ziprasidone (Geodon).

NEWSLETTER: What other drugs besides the anti-obsessionals (SSRIs) that are used to treat OCD can cause weight gain?

GORBIS: Antipsychotic medication, such as, Zyprexa, Risperdal and Seroquel, are the most common non-antiolesional medications used to treat OCD. All three of these drugs can cause weight gain as well. Researchers have looked specifically at adolescents and found that

(continued on page 4)

In This Issue

- Affiliate Newsp. 2
- PET Scan Researchp. 3
- UCLA Hoarding Researchp. 5
- Research Digest.....p. 6
- MGH Research Programp. 7
- "Bad Hair Life," a Review.....p. 9
- My OCD Notebookp. 14

News of Affiliates, Support Groups and Friends of The Foundation

A CELEBRATION FOR GENETICS RESEARCH

Henry, Karyn and Elyse Monti invited their friends and family to their home in East Greenwich, Rhode Island, on Friday evening, June 6, 2003 for a "Benefit for the Obsessive-Compulsive Foundation." Henry and Karyn put on this benefit to honor their daughter Elyse. Elyse has OCD. But she hasn't allowed it to control her life. After being treated successfully, Elyse, who is a senior in high school, organized the first OCD support group for teens in Rhode Island. She also was the force behind the Foundation's formation of the Young Leaders Group, which met for the first time at the OCD Conference in Nashville this summer.



Enjoying the evening at the Monti Fundraiser (front row from left to right) Karyn Monti, Henry Monti and daughter, Elyse. Standing are Patricia Perkins, Dr. Steven Rasmussen from Butler Hospital and Joy Kant, treasurer of the OCF Board of Directors.

The Montis raised \$13,650.00 for genetics research. This money will be used to partially underwrite the 2003 OCF Research Award given to Drs. Karen Weissbecker and Humberto Nicolini, both members of the OCF Genetics Collaborative, for their study, "Clinical and Genetic Studies of OCD With and Without Tics." Both the OCF Scientific Advisory Board Review Committee and the OCF Board of Directors felt that this project should receive an OCF Research Award because it will help to establish whether OCD is homogeneous (having a single cause) or heterogeneous (having different causes). The answer to this question is critical to finding effective treatments.

OCFMC FUNDRAISER WAS A BIG SUCCESS

Submitted by Ellen Sawyer, Executive Director, OCFMC

The Obsessive Compulsive Foundation of Metropolitan Chicago (OCFMC) hosted its annual benefit on April 5, at the north sub-

urban Woman's Club of Wilmette. The event's theme, *A Stellar Evening*, set the tone for a highly successful fundraiser that netted \$57,000 for the organization.

Some 200 attendees began the evening with cocktails and a lavish dinner buffet prepared by chefs from the renowned Kendall College School of Culinary Arts. From there, they perused and bid on a wide range of silent auction items from sports and entertainment memorabilia and restaurant packages to massages and theatre tickets.

The evening's entertainment featured a satirical musical revue performed by the infamous Chicago Bar Association troupe. Known around Chicagoland for their humorous spin on current events, the group's lighthearted touch counterbalanced the seriousness of OCD as a disorder and its profound effects on so many people's lives.

The evening ended with a spirited "The Sky-is-the-Limit" live auction, emceed by a professional auctioneer. Items ranged from a luxurious spa vacation at an Arizona resort to a handmade quilt created from squares made by children with OCD.

"The turnout was wonderful, and we're grateful for the generous contributions we received from so many people," said Randi Frankel, who co-chaired the event along with Jan Emmerman.



OCFMC President, Susan Richman, and Benefit Co-Chair, Randi Frankel, stop for a moment in front of the children's handmade quilt sold at the live auction.

"The proceeds from the benefit will go a long way in helping us continue our work on behalf of people with OCD and their families," said Susan Richman, OCFMC president.

(continued on page 15)

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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.

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

UCLA Is Using PET Scans In OCD Research

In a recent interview with the OCD Newsletter, Dr. Sanjaya Saxena and therapist, Karron Maidment, talked about their research using PET scans to investigate the effect of CBT on adults with OCD.

NEWSLETTER: What are you looking for in your PET/CBT/Neurocognitive Testing Study?

SAXENA / MAIDMENT: This study will examine regional brain activity as measured by positron emission tomography (PET) scans and neurocognitive performance in adults diagnosed with obsessive-compulsive disorder (OCD), before and after four weeks of treatment with intensive cognitive-behavioral therapy (CBT), with or without medication. This study is similar to our PET/Paxil study in that we are looking at changes in brain activity in specific regions of the brain that occur with treatment. In this case the treatment we are using is intensive CBT, conducted 5 days/week for 4 weeks. We are also looking at how neurocognitive functions, such as, memory, attention, language, and visual-spatial abilities change with intensive CBT for OCD.

The overall goals of this study are to better understand how CBT works in OCD by determining how it affects the functioning of the brain, as measured by PET scans that show brain activity, as well as neurocognitive performance. This will also help us better understand the underlying neurobiology of OCD and its response to treatment.

The specific objectives of this study are:

1. To identify the brain systems that mediate response to intensive CBT in OCD. We also wish to find out whether the changes in brain activity previously seen after 12 weeks of conventional weekly CBT can be significantly accelerated by intensive CBT to be attained in only 4 weeks. No prior study has ever shown changes in brain function in such a short time period in patients with OCD, which is notoriously slow to respond to treatment. Our intensive CBT method has already shown excellent clinical efficacy in 4 weeks, a dramatic acceleration of treatment response. Thus, it makes sense now to determine whether this rapid response is accompanied by the same (or different) brain functional changes that have been associated with slower response in many previous studies. Results from this study could have important ramifications for our understanding of the brain mechanisms of treatment response in OCD and for how it will be treated in the future.

2. To determine whether the neurocognitive

abnormalities associated with OCD improve or change after intensive CBT. This would help us understand whether they are trait or state markers of OCD. It also helps us determine how CBT works. We also plan to examine the links between changes in regional brain metabolism, neurocognitive deficits, and OCD symptom severity.

3. To determine whether the changes in brain activity associated with response to intensive CBT are the same or different as those produced by response to medication treatment. Subjects in a parallel study receive 12 weeks of free medication treatment with Paxil for their OCD.

NEWSLETTER: What does this study involve? How long is it?

SAXENA / MAIDMENT: This study is 5 weeks long. It involves having two PET scans of the brain, one just before and one after treatment with intensive CBT. It also involves receiving a battery of neurocognitive tests before and after treatment. Each patient will also receive a magnetic resonance imaging (MRI) scan of the brain.

NEWSLETTER: Please describe the 4-week intensive CBT program in which each participant will be involved.

SAXENA / MAIDMENT: All participants receive 4 weeks of intensive CBT that consists of daily 90-minute sessions of exposure and response prevention (ERP), followed by daily structured home assignments conducted under close supervision. ERP is the behavioral treatment of choice for OCD. ERP involves the gradual exposure of a person to the object or situation that causes anxiety. During an exposure, which leads to an initial increase in anxiety, patients are encouraged to resist their urges to ritualize in both treatment and non-treatment settings. The patient is then supported as he resists the urge to do his compulsions. This ultimately leads to a decrease in anxiety. The treatment also includes cognitive and mindfulness techniques and a relapse prevention module. Treatment is done on a one-on-one basis with Dr. Eda Gorbis, a specialist in intensive CBT for OCD.

NEWSLETTER: How many days a week and hours a day will the CBT sessions be? How many weeks will the study last?

SAXENA / MAIDMENT: The treatment is five days a week for 1 1/2 hours each day, plus homework exercises. It last for 4 weeks.

NEWSLETTER: Will the intensive CBT be provided to study participants free of charge?

SAXENA / MAIDMENT: Yes.

NEWSLETTER: Will there be monetary compensation for individuals who take part in this study? Will there be travel reimbursement?

SAXENA / MAIDMENT: No. All participants will receive free CBT, free PET and MRI scans, and free neurocognitive testing.

NEWSLETTER: What is neurocognitive testing? How does it relate to OCD? What are you looking for with the neurocognitive testing?

SAXENA / MAIDMENT: The neurocognitive testing done in this study measures several aspects of thinking, including memory, attention, language, fine motor coordination, visual-spatial abilities, and problem-solving skills. Many previous studies have found neurocognitive abnormalities in OCD, but it is unclear whether these are stable trait features of the illness, or whether they improve with treatment. This study will determine if neurocognitive performance changes with intensive CBT. The neurocognitive testing includes four general tests, each with several subtests, designed to investigate specific areas of mental processing. The Executive Functions portion tests ability to form concepts, plan and sequence information. It looks at language patterns and attention. The Memory Functions portion tests verbal and nonverbal recall in various time periods. The Visual/Spatial Functions portion tests abilities to perceive and work with visual stimuli. The Psychomotor Functions portion assesses fine motor coordination.

NEWSLETTER: Give our readers some examples of the kinds of questions that will be asked?

SAXENA / MAIDMENT: Some examples would be questions about specific types of memory. A patient might be asked to remember details from a story, or look at a list of objects and try to remember the list later on in the session, or to remember the details of an abstract figure drawing. Other tests examine a patient's ability to solve different kinds of puzzles.

NEWSLETTER: How long will the neurocognitive testing take? How many times will a participant have to take it? Will someone go over the results of this test with the individuals who took it?

SAXENA / MAIDMENT: The neurocognitive tests will take 1 1/2 to 2 hours to complete. They are done before and after the four weeks of treatment with intensive

Weight Gain

(continued from page 1)

Zyprexa and Risperdal caused significant weight gain. Average weight gain was significantly higher for the Risperdal group than for the Zyprexa group. Patients on Haldol didn't change. Other data suggest that Geodon does not cause weight gain in most individuals. Authors noted that adolescents are more likely to gain weight on medications than adults.

NEWSLETTER: Why do these medications cause weight gain?

GORBIS: Medications create sedation which requires more sleep and rest, which in turn causes a decreased amount of activity. SSRIs also create a craving for carbohydrates. Patients who are treated with SSRIs increase their carbohydrate intake significantly shortly after beginning treatment. Very often patients do not report that they are eating more than before. Therefore, it is tempting to hypothesize that there is a drug-induced decrease in metabolism. However, there is no substantial data that supports this hypothesis and there is only one paper that proves such change in metabolism. The authors of this paper have stated that weight gain fluctuations reflect changes between caloric intake and caloric expenditure. Weight gain is due to an increase in the amount of calories consumed. The resting metabolic rate reflects the number of calories utilized by an individual in the resting state. At least 70% of the daily calories burned by an individual are burned during the resting state. So, if a reduction in metabolic rate occurs, an individual would gain weight without increasing calories because s/he is resting more.

NEWSLETTER: Is weight gain unavoidable when using these drugs?

GORBIS: Yes and no. As mentioned above, weight gain is due to the sedative effects of medication and the concomitant decrease in metabolic rate. If a therapist anticipates a weight gain, s/he will usually initiate an anticipatory pre-cognitive intervention before the patients begins to gain weight. In other words, the therapist will start preparing a patient for possibly gaining weight and teach her ways to manage her weight. The strategies include: keeping a daily food diary, exercising more, and decreasing caloric intake, especially in the form of carbohydrates.

NEWSLETTER: Do these drugs lower one's metabolism?

GORBIS: The results suggest that weight gain is at least partially due to a decrease in the metabolic rate. SSRIs affect the brain chemical called serotonin, which in turn affects appetite and food intake.

NEWSLETTER: Do these medications affect men and women differently? Adolescents and adults?

GORBIS: There is no empirical evidence to substantiate the answer that there is a difference in weight gain patterns between men and women. But, adolescents are more likely to have a

greater weight increase. However, because everybody's metabolism and body are different, there will be different responses to different doses of medication.

NEWSLETTER: Do some medications have more of a propensity to cause weight gain than others?

GORBIS: Yes. For example, Risperdal causes more weight gain than Zyprexa. Paxil causes up to 25% more weight gain than Prozac and Zoloft. Some studies also indicate that with Celexa weight gain is minimal or nonexistent. However, those findings are tentative.

NEWSLETTER: How can a person prevent or minimize weight gain?

GORBIS: Weight gain can be minimized or prevented with a specially tailored program where a doctor and patient have a partnership agreement in which the patient agrees to adhere to certain rules. The rules include behavioral interventions, such as, keeping a food intake diary and faxing it to the doctor on a daily basis. This is done so that the doctor can monitor the food intake and make any adjustments when needed.

NEWSLETTER: Will diet and exercise affect weight gains caused by medication?

GORBIS: Yes. It is particularly helpful if one has some kind of sports activity as a hobby. As you know, there are two psychological motivators: the avoidance of pain and the desire for pleasure. People are more likely to do things that they enjoy. During exercise, endorphins are released that cause a certain level of pleasure, which in turn increases the amount of activity. In my practice, I always use the slogan, "Mind over matter."

NEWSLETTER: How do you deal with medication-induced weight gain in your practice? Do you introduce the topic when a patient begins taking the medication?

GORBIS: As I mentioned above, if I anticipate a weight gain in a patient, I introduce behavioral intervention prior to starting the medication. It is important to prepare patients for possible side effects, such as, weight gain. I also teach them how to manage these effects. I start with educating patients about their diet and exercise and what adjustments they may need to make to control their weight while on medication. I also make a contract with a patient that s/he will keep a daily food diary and fax it to me.

NEWSLETTER: Can weight gain be prevented completely? How?

GORBIS: Weight gain like everything else is related to one's mind-body relationship. Adjustments usually need to be made to the diet and the amount of exercise done on a regular basis to control any weight gain that might accompany taking an SSRI. However, other factors, such as, heredity, are also involved. It is always an interaction of biology and environment. Nevertheless, usually a healthy diet and adequate exercise are really important in getting one's weight under control whatever the circumstances. In addition, it is important to note that the effects of medication can vary from person

to person. The possible and actual side effects of a medication need to be discussed with each patient in the same way that a medication and its dosage need to be tailored to each individual.

NEWSLETTER: Is there a way to eat to avoid gaining weight? What kind of diet do you prescribe?

GORBIS: I tell my patients to drink a lot of water (up to 10 glasses a day). I also tell them to decrease their carbohydrate intake and increase their consumption of protein. I suggest that they eat whole grain foods too. There are several other techniques that are helpful. For example, a patient needs to dedicate a set time for eating. This means no eating on the go. Furthermore, before sitting down to a meal, it is advisable to drink two glasses of water. Drinking water prior to eating curbs one's appetite. Because of the caffeine, drinking diet cola or coffee will also decrease one's appetite.

NEWSLETTER: Does someone on SSRIs have to stop eating certain kinds of food to avoid gaining weight?

GORBIS: Someone taking an SSRI should decrease his/her consumption of carbohydrates and eat more proteins as well as fruits and vegetables.

NEWSLETTER: Will exercise help curb weight gain?

GORBIS: Exercise burns calories; so it helps curb weight gain.

NEWSLETTER: What types and how much exercise should someone on SSRIs do to control weight gain?

GORBIS: I recommend 30 minutes of exercise, 4-5 times a week. The type of exercise is not the most important factor. People are usually more likely to continue to do something that they enjoy. An exercise plan should be built around the sports activities one enjoys.

NEWSLETTER: Does the weight gain ever level off or stop?

GORBIS: It doesn't stop. However, some people are more genetically prone to gaining weight. So, unfortunately, they are more likely to gain more and to continue on gaining unless they utilize diet and exercise.

NEWSLETTER: What suggestions do you give your patients for stabilizing their weight once they've lost the amount they wanted to lose?

GORBIS: Continue the program they used. It is all about lifestyle changes. Once you've lost the weight, it does not mean that you are going to stay this way forever. If you go back to your old eating habits, it is only a matter of time until the weight comes back.

NEWSLETTER: Are there any medications that someone can take to offset the weight-gaining effects of SSRIs?

GORBIS: If the weight gain is not controlled despite dieting and exercise, talk to your psychopharmacologist. There are several medications that can help: Ritalin, Topamax and Cytomel.

INVESTIGATORS AT UCLA ARE USING PET SCANS TO STUDY COMPULSIVE HOARDING

The following is an interview with Sanjaya Saxena, M.D., and Karron Maidment, R.N., M.A., from the OCD Intensive Treatment Program at UCLA about their compulsive hoarding study.

NEWSLETTER: The UCLA group is doing a study on the neurobiology and treatment of compulsive hoarding in which people with the compulsive hoarding syndrome will be treated with Paxil. How long is this study and will you be doing PET scans and MRIs on the people taking part in this study?

SAXENA/MAIDMENT: Hoarding and saving symptoms found in up to 30% of OCD patients are part of a discrete clinical syndrome that also includes indecisiveness, perfectionism, procrastination, and avoidance. This syndrome responds poorly to standard treatments for OCD and can become disabling. Yet, despite its common occurrence and clinical significance, the neurobiology of compulsive hoarding has never before been investigated. Furthermore, there have been no medication treatment studies specifically targeting this syndrome. A better understanding of the neurobiology of compulsive hoarding is needed to develop more effective treatments for it.

Functional brain imaging research using positron emission tomography (PET) has led to a greater understanding of the neurobiology of OCD. Our study uses PET to identify patterns of brain activity that are specifically associated with the compulsive hoarding syndrome. PET scan data from patients with compulsive hoarding will be compared with data from other OCD patients and normal control subjects to identify brain metabolic patterns that differentiate them and that may predict response to particular treatments.

Our PET/Hoarding study is identical to the PET/Paxil study that we are doing for people who have other types of OCD. It is 12 weeks long and involves having positron emission tomography (PET) scans of the brain both before and after 12 weeks of treatment with Paxil (paroxetine), a serotonin reuptake inhibitor (SRI) medication proven effective and FDA-approved for the treatment of OCD. It also involves having a magnetic resonance imaging (MRI) scan of the brain at some point during the treatment period. Eligible participants can also elect to have only the PET and MRI scans without receiving any treatment.

NEWSLETTER: How many PET scans will each participant have? When will they have them? What are you looking for in the PET scans?

SAXENA/MAIDMENT: Each patient will

have two PET scans, one at the beginning and one at the end of treatment. The PET scans serve several purposes. They show the activity of the brain as measured by the rate of glucose metabolism. Many PET studies have shown abnormal patterns of brain activity in people with OCD. More significantly, these abnormalities improve significantly with response to treatment. As in our PET/Paxil and PET/CBT studies, we are examining specific brain regions that show abnormal activity in patients with OCD and measuring the changes in brain activity from before to after treatment. This allows us to find out which brain areas mediate different clusters of symptoms, such as, OCD symptoms versus depression symptoms. We are also identifying pre-treatment patterns of brain activity that predict response to specific treatments for OCD in hopes that that we might someday be able to tailor treatment to each individual based on their own unique pattern of brain activity.

In the PET/Hoarding study, we are investigating whether patients with the compulsive hoarding syndrome have a different pattern of brain activity than patients with other types of OCD. Our preliminary research suggests that compulsive hoarders show abnormalities in different parts of the brain than people with other types of OCD. This may partly explain why compulsive hoarding does not always respond well to standard treatments that work for other OCD symptoms. This study will help us better understand the neurobiology of compulsive hoarding and, hopefully, lead to better treatments for it.

NEWSLETTER: At what point in the trial will the MRIs be done? How many will each participant have? What are you expecting to learn from the MRIs?

SAXENA/MAIDMENT: MRI scans are standard medical procedures. Each patient in our study receives one MRI of the brain, which can be done at any point during the twelve weeks of treatment with Paxil, between the first and second PET scans. The MRI scan gives a great deal of information. First, it tells us if there are any structural abnormalities in the brain, such as, cysts, tumors, strokes, or atrophy. Should anything abnormal show up on the MRI, the patient is informed immediately and referred for appropriate evaluation or treatment. Secondly, the MRI is used to more accurately map the brain regions on the PET scan. We 'overlay' the PET scan image over the MRI image for each patient in order to more accurately identify the precise boundaries of the brain regions that we are examining. Thirdly, the MRIs will help us determine whether people with compulsive hoarding have different volumes or shapes of specific brain regions when compared to non-hoarding OCD patients and controls.

NEWSLETTER: Who would be eligible to participate in this trial? What criteria would they have to meet?

SAXENA/MAIDMENT: People with the compulsive hoarding syndrome who are between the ages of 18-65 years, in good physical health and not on any psychiatric medications are eligible for the study. We cannot treat pregnant women or people with other major psychiatric disorders besides OCD, such as, schizophrenia, bipolar disorder, alcohol or drug abuse, panic disorder, or mental retardation. People with other active medical and neurological diseases must also be excluded.

NEWSLETTER: How will you determine if someone is a compulsive hoarder? How will you measure whether he or she has improved on Paxil over the course of the study? What types of assessments will you be using?

SAXENA/MAIDMENT: Drs. Frost and Steketee have established clinical criteria for compulsive hoarding:

- the acquisition of and inability to discard items that others would deem useless or of limited value
- the inability to use living spaces for their intended purposes because they are so cluttered
- the hoarding and clutter causes significant impairment in functioning

We diagnose a person as having the compulsive hoarding syndrome if: 1) they meet those criteria; 2) hoarding and saving symptoms are their primary type of OCD that causes the greatest distress and impairment; and 3) they have other elements of the syndrome, such as, indecisiveness, procrastination, and perfectionism. We use a number of questionnaires and rating scales to assess each patient's symptoms and behaviors. We have developed a new scale that specifically assesses the severity of hoarding, saving, clutter, and the other symptoms found in the compulsive hoarding syndrome. We are currently in the process of validating this scale. We also use standard rating scales to measure symptom severity, including the Yale Brown Obsessive Compulsive Scale (Y-BOCS), the Hamilton Depression and Anxiety Scales to measure the severity of depression and anxiety symptoms, and a scale that measures overall functioning. Rating scales are administered immediately before and after treatment.

NEWSLETTER: Who will be the lead investigator on this study? What is his/her background and experience in the area?

SAXENA/MAIDMENT: Sanjaya Saxena, M.D., is the Principal Investigator for this study. Dr. Saxena is the Director of the UCLA OCD

(continued on page 8)

Research Digest

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

The first article below provides further evidence that both behavior therapy (BT) and serotonin reuptake inhibitors (SRIs) are effective in the long-term treatment of OCD. SRI medications were equally as effective as BT, provided the patients stayed on the medication. If medication was withdrawn, the long-term outcome was superior following BT. This study supports our personal view that BT should always be part of OCD treatment. Before considering alternative treatments, especially neurosurgery (also referred to as psychosurgery), it is important that proven treatments have been tried and have been ineffective. Neurosurgery articles were reviewed earlier this year (Spring issue). There is a high interest in this topic and we are reviewing additional papers.

Long-term efficacy of exposure and ritual prevention therapy and serotonergic medications for obsessive-compulsive disorder

CNS Spectrums, 8:363-371, 381, 2003, E.A. Hembree, D.S. Riggs, M.J. Kozak et al.

This is a follow-up study, an average of 17 months after treatment, conducted with 62 patients treated for OCD. Patients received one of three treatments: SRI medications (fluvoxamine [Luvox] or clomipramine [Anafranil]), intensive behavior therapy (BT) using exposure plus ritual prevention or intensive BT plus medication. BT, SRI medications and the combination of BT with SRIs were all equally effective at follow-up. Differences were found for those patients who discontinued medication. Patients who received BT had lower symptoms severity ratings than patients in the medication only group who discontinued medication. Over 70% of patients in the BT groups (BT alone and BT plus SRI) and over 50% of patients in the drug-only group were considered treatment responders at follow-up. The lower percentage of responders in the drug-only group was related to those who had discontinued medication; patients continuing medication maintained their response. These results suggest that long-term outcome may be superior following BT than following medication treatment, if medication is withdrawn. Results also support the use of augmenting SRI treatment with BT. Addition of BT to existing SRI treatment may allow patients to discontinue medi-

cations without experiencing a significant return of symptoms.

Neurosurgery for intractable obsessive-compulsive disorder and depression: critical issues

Neurosurgery Clinics of North America, 14:199-212, 2003, B.D. Greenberg, L.H. Price, S.L. Rauch

Authors present a history of neurosurgery for OCD beginning with crude lobotomies and continuing through modern and more focused surgeries, tractotomy, capsulotomy, cingulotomy and leucotomy. The effectiveness and safety of these procedures are reviewed. Lastly, unresolved issues and needed research are presented. They conclude that research to date "provides grounds for careful optimism" that neurosurgery may be beneficial for OCD.

Anterior cingulotomy for refractory obsessive-compulsive disorder

Acta Psychiatrica Scandinavica, 107:283-290, 2003, C.H. Kim, J.W. Chang, M.S. Koo et al.

This study investigated the effectiveness and adverse effects of cingulotomy, a neurosurgical procedure creating lesions in the anterior cingulate cortex of the brain, for treatment-resistant OCD. Out of 14 patients, 6 patients responded to cingulotomy. In the 12-month follow-up, OCD symptoms continued to improve. It is important to note that all patients received OCD medication treatment after surgery. As reported in earlier studies, there was generally a delay in the onset of response. Regarding adverse effects, there were no significant changes in cognitive function and memory one year after surgery compared with the pre-surgery evaluation. Three patients experienced memory problems after surgery, but these lasted less than 2 months. This study found no evidence of cognitive changes including effects on intelligence and memory after cingulotomy. There were side effects of headache, insomnia and weight changes but these did not continue beyond 3 months.

Status of neurosurgery for mental disorder in Scotland: selective literature review and overview of current clinical activity

British Journal of Psychiatry, 182:404-411, 2003, K. Matthews and M.S. Eljamel

Evidence supporting neurosurgical treatment of OCD and adverse effects of the procedures are reviewed. A Scottish national service, Good Practice Group, recommended that neurosurgery for mental disorders should continue to be available in Scotland, but only as treatment for non-responding OCD and depression. Activities of the clinical service at the Dundee Royal Infirmary in Scotland, a joint service established by the psychiatry and surgical neurology departments, are described. Only 34 neurosurgeries for mental disorders were performed between 1990 and 2001, a small number that re-emphasizes the point that neurosurgery is an investigational treatment at this time.

Deep brain stimulation (DBS) uses an electrical current from implanted electrodes to disrupt neural transmission in specific brain regions. The appeal of DBS is that the disruption only occurs when the electrical stimulator is "on" and the implanted stimulators are removable. Thus, DBS is a reversible procedure. Nuttin et al. report their study in two papers; first, anecdotal case reports with some observations that interested the authors; and second, results from a 21-month follow-up.

Electrical stimulation of the anterior limbs of the internal capsules in patients with severe obsessive-compulsive disorder: anecdotal reports

Neurosurgery Clinics of North America, 14:267-274, 2003, B.J. Nuttin, L. Gabriels, K. van Kuyck et al.

Six individuals with treatment-resistant OCD received DBS, in which electrodes were implanted in the anterior limbs of internal capsules of the brain. Authors report observations that interested them and patients' personal responses to DBS. All six patients improved with DBS, but when batteries wore out the OCD symptoms returned to their former severity over the course of a few days. One individual had the electrodes removed because he felt the leads (wires) were uncomfortable, he had only marginal improvement in OCD symptoms and he did not like the frequent procedure

Research Digest

involved in replacing the stimulators. Two patients were given programmable devices to change stimulator intensity as needed, for example, lower amplitude stimulation when more relaxed at home and higher amplitude when in a crowd. Other methods to decrease battery consumption were tried, such as, switching off the stimulation at night and trying 1-minute on/1-minute off stimulation. Researchers stress that DBS remains investigational and improvement is needed, such as, solving the problem of short battery life as stimulators had to be replaced every 5 to 12 months.

Long-term electrical capsular stimulation in patients with obsessive-compulsive disorder

Neurosurgery, 52:1263-1274, 2003, B.J. Nuttin, L.A. Gabriels, P.R. Cosyns et al.

Six individuals with treatment-resistant OCD received DBS. The subjective report of their experiences is presented in the paper above. A double-blind, clinical assessment of four of these patients is reported here. Patients were assessed with stimulators on and off.

During the stimulation-off period, OCD symptoms approached pretreatment severity. Results showed that DBS induced a significant decrease in OCD symptoms as evaluated by psychiatrists and patients who were blinded to treatment conditions. The response was maintained for at least 21 months with continuous stimulation. The article concludes with comments by other researchers on the safety and feasibility of DBS.

Treatment of patients with intractable obsessive-compulsive disorder with anterior capsular stimulation: case report

Journal of Neurosurgery, 98:1104-1108, 2003, D. Anderson and A. Ahmed

Deep brain stimulation (DBS) was effective for a 35-year-old woman with a 10-year history of treatment resistant OCD. She had previously worked but had reached the point she was unable to work. After 3 months of DBS, she reported dramatic improvement in her symptoms, an improvement measured by a reduction in her Y-BOCS score of 34 to 7. At her 10-month follow-up visit, she reported she had returned to work.

Investigators At MGH OCD Clinic Study Cognitive Changes After ERP

The following is an interview with Sabine Wilhelm, Ph.D., clinical director of the OCD Clinic at Massachusetts General Hospital, about her study on the impact of ERP on different types of OCD symptoms.

NEWSLETTER: Dr. Wilhelm, what are you trying to discover through your behavior therapy study for OCD?

DR. WILHELM: The purpose of the study is to investigate the underlying mechanisms of improvement of Exposure and Response Prevention (ERP) for patients suffering from OCD. The main goals of the proposed project are: (1) to determine the ERP impact on different types of symptoms in OCD patients, (2) to examine whether a generalization of treatment effects occurs, i.e., not only the treated symptoms but also the untreated symptoms improve, and (3) to analyze possible mechanisms of treatment and transfer effects.

NEWSLETTER: Why is this study important?

DR. WILHELM: Specifically, we intend to identify the cognitive changes that underlie therapeutic improvement using ERP treatment. To do this, the current study provides OCD patients with ERP treatment for some of their OCD symptoms (e.g., contamination) while leaving other symptoms (checking, hoarding) untreated. The symptom changes and the cognitive variables we assume to have an impact on those changes will be measured in both the treated OCD symptoms and the untreated OCD symptoms. We hypothesize that treatment benefits will generalize from the treated to the untreated OCD symptoms. We also predict that certain OCD specific beliefs will predict treatment and transfer effects. If we can learn more about what kind of cognitive changes are associated with improvements in symptoms, we can maximize those cognitive changes in future treatments.

NEWSLETTER: Where does this study take place?

DR. WILHELM: The treatment study takes place at the Massachusetts General Hospital/Harvard Medical School. The OCD Clinic is in Charlestown, Massachusetts.

NEWSLETTER: What are the eligibility criteria for being in this study?

DR. WILHELM: Adults with OCD who live within commuting distance to our clinic can participate. If patients suffer from current alcohol or drug abuse, psychosis or a history of psychotic disorders or are actively suicidal, they cannot participate. If patients have any other comorbid disorders, the OCD symptoms have to be the primary concern. Furthermore, participants cannot participate if they did not improve with 10 or more sessions of previous ERP treatment. Also, if the potential participants take psychotropic medication, they have

to stay on a stable dose for at least 2 months before they can participate.

NEWSLETTER: Exactly what will a participant be volunteering for?

DR. WILHELM: First, the participant will take part in a pre-treatment assessment which will take about 3 to 4 hours. The participant will then be treated with 22 sessions of ERP (once or twice per week). Every 4 weeks, the participants will also be assessed with respect to the severity of OCD symptoms, anxiety and depression.

NEWSLETTER: Will a participant have access to medication during the study? If he or she is already on medication, will it have to be stopped or can it be continued?

DR. WILHELM: The study does not provide any medication. However, if participants are already on medication, they can continue to take it over the course of the study as long as their dose remains stable.

NEWSLETTER: What if a participant finds he cannot do the behavior therapy?

DR. WILHELM: The participation in this treatment study is completely voluntary. If the participant cannot or does not want to do behavior therapy, we could potentially refer him or her to other treatments that are currently being provided here at the OCD Clinic.

NEWSLETTER: Is there any follow-up treatment available? Will there be a charge for follow-up treatment?

DR. WILHELM: After a participant has completed the treatment study he or she can be referred for follow-up treatment in our clinic. Free treatment is available for low-income participants.

NEWSLETTER: Who will be doing the behavior therapy with the participants?

DR. WILHELM: Treatment will be delivered by trained OCD therapists who will meet with me for weekly supervision.

NEWSLETTER: Will participants receive any money for taking part in the study? Will they be paid for travel expenses, etc.? Why should someone take part in your study?

DR. WILHELM: The participants won't receive any money for their participation or travel expenses. However, they may directly benefit from the treatment in terms of their improvement in OCD symptoms. Moreover, participating in this study will help advance our understanding of the treatment of OCD.

NEWSLETTER: With whom should readers get in touch if they are interested in participating in this study?

DR. WILHELM: Anyone who is interested in this study should contact Dr. Ulrike Buhlmann at (617) 726-5374 or at buhlmann@nmrmgh.harvard.edu.

Pet Scan Research on OCD at UCLA

(continued from page 3)

CBT. The testing is performed by a neuropsychologist with extensive experience in OCD, who can review the results with participants who are interested.

NEWSLETTER: How long is the study? How many sessions will participants have to attend? How long are the sessions?

SAXENA/MAIDMENT: The study is 5 weeks long. There are two PET scans, each 3 to 3 1/2 hours long. The MRI is one session, about 45 minutes long. There are two sets of neurocognitive testing. The first is 1 1/2 to 2 hours long and the second is 1 to 1 1/2 hours. There are 20 sessions of CBT. Each session is 90 minutes long, followed by homework exercises.

NEWSLETTER: Participants in this study will have two PET scans of their brains; one before and one after the four weeks of intensive CBT. What will you be looking for in these scans?

SAXENA/MAIDMENT: The PET scans serve several purposes. They show the activity of the brain, as measured by the rate of glucose metabolism. Many PET studies have shown abnormal patterns of brain activity in people with OCD. More significantly, these abnormalities improve significantly with response to treatment. As in our PET/Paxil study, we are examining specific brain regions that show abnormal activity in patients with OCD and measuring the changes in brain activity from before to after treatment. This allows us to find out which brain areas mediate different clusters of symptoms, such as, OCD symptoms versus depression symptoms. In this study, we are investigating the brain mechanism of action of intensive CBT by measuring the effect of CBT on brain activity, as seen on the PET scans. We want to find out whether intensive CBT has the same, or different effects on brain activity, as medication treatment. We also want to find out whether short-term, 4 week intensive CBT can produce the same brain changes generally seen only after longer treatments, such as, 12 weeks of medication or standard weekly CBT. We also hope to identify pre-treatment patterns of brain activity that predict response to CBT for OCD, in hopes that that we might someday be able to tailor treatment to each individual, based on his own unique pattern of brain activity.

NEWSLETTER: Participants will also have an MRI scan of the brain as part of this study? When will that be done? Why is an MRI scan being done? What do you expect these scans to tell you about the brains of people with OCD?

About the effect of CBT on brain functioning?

SAXENA/MAIDMENT: MRI scans are standard medical procedures. Each patient in our study receives one MRI of the brain, which can be done at any point during the twelve weeks of treatment with Paxil, between the first and second PET scans. The MRI scan gives a great deal of information. First, it tells us if there are any structural abnormalities in the brain, such as, cysts, tumors, strokes, or atrophy. Should anything abnormal show up on the MRI, the patient is informed immediately and referred for appropriate evaluation or treatment. Secondly, the MRI is used to more accurately map the brain regions on the PET scan. We 'overlay' the PET scan image over the MRI image for each patient, in order to more accurately identify the precise boundaries of the brain regions that we are examining. Thirdly, the MRIs will help us determine whether people with OCD have different volumes or shapes of specific brain regions, as compared to controls.

NEWSLETTER: Who is the lead investigator on this study? What is his/her experience with CBT and neurological functioning?

SAXENA/MAIDMENT: Sanjaya Saxena, M.D., is the Principal Investigator for this study. Dr. Saxena is the Director of the UCLA OCD Research Program and Associate Director of the UCLA Anxiety Disorders Program. He has been treating patients with OCD and doing research on brain imaging and treatment of OCD for the last 10 years. Dr. Saxena is an Associate Professor in the UCLA Department of Psychiatry and Biobehavioral Sciences and is a member of the OCF Scientific Advisory Board. He has won numerous grants and awards for his work in OCD and has published over 30 scientific articles and chapters.

NEWSLETTER: Who will be doing the intensive cognitive behavior therapy with the individuals who agree to be in this study?

SAXENA/MAIDMENT: All participants will receive intensive CBT with Eda Gorbis, Ph.D., MFCC. Dr. Gorbis has been specializing in the intensive treatment of patients with OCD for about 10 years and has extensive experience in this area. She is an Assistant Clinical Professor in the UCLA Department of Psychiatry and a member of the OCF Scientific Advisory Board.

NEWSLETTER: If a reader is interested in participating in this study, whom should s/he contact and how?

SAXENA/MAIDMENT: Contact Karron Maidment, RN, M.A., at (310) 794-7305 and refer to the PET/CBT study.

COMPULSIVE HOARDING STUDY AT UCLA

(continued from page 5)

Research Program and Associate Director of the UCLA Anxiety Disorders Program. He has been treating patients with OCD and doing research on brain imaging and treatment of OCD for the last 10 years. Dr. Saxena is an Associate Professor in the UCLA Department of Psychiatry and Biobehavioral Sciences and is a member of the OCF Scientific Advisory Board. He has won numerous grants and awards for his work in OCD and has published over 30 scientific articles and chapters.

Karron Maidment, RN, M.A., is the Research Coordinator for this study. Karron has been working with OCD patients in both a clinical and research capacity for the last 16 years.

NEWSLETTER: Will there be in-home meetings to determine the extent of the hoarding?

SAXENA/MAIDMENT: No. But we often ask patients to bring photographs of their home so that we can assess the extent of the clutter.

NEWSLETTER: What if a patient cannot tolerate the medication or any of its side effects? Will s/he be dropped from the study? Will s/he be offered alternative therapy?

SAXENA/MAIDMENT: If a person develops side effects and cannot tolerate Paxil, even at a low dose, he or she will be taken off the medication and will no longer participate in this study. The Principal Investigator will recommend other treatment options for the patient, including other medications and/or cognitive-behavioral therapy. All participants are given referrals for continued treatment after they finish the study. Patients can receive treatment either at UCLA or from a private clinician of their choice.

NEWSLETTER: How will you measure the efficacy of the medication?

SAXENA/MAIDMENT: This study is not testing the efficacy of Paxil for OCD, which is already well established. It is looking at changes in brain metabolism after treatment in different groups of patients. The effect of the medication in each patient is assessed by the standardized rating scales that measure changes in the severity of hoarding, other OCD symptoms, depression, anxiety, and overall functioning.

NEWSLETTER: Will there be any post-trial follow-up? What will it be? Will it be free?

(continued on page 9)

COMPULSIVE HOARDING STUDY AT UCLA

(continued from page 8)

SAXENA/MAIDMENT: After patients complete this study, they are eligible for other studies at UCLA. We currently have studies of add-on medications for patients who have not had an adequate response to Paxil alone. We also have a study that involves genetic and neurocognitive testing. There is no other follow-up planned.

NEWSLETTER: Will there be any monetary compensation given to participants? Will they be reimbursed for travel expenses?

SAXENAMAIDMENT: No and No. Patients receive 12 weeks of free treatment with Paxil, as well as free PET and MRI scans.

NEWSLETTER: If a participant reports significant improvement on the medication, will s/he be allowed to continue on it? Will it be supplied to him/her at no cost for a set period of time?

SAXENAMAIDMENT: At the conclusion of the study, if patients have had a good response to Paxil, we encourage them to stay on it and refer them to a physician who can continue prescribing it, either at UCLA or in the community. However, the medication will not be free after the 12 week study period. If they have not had a good response, they are eligible for one of the studies of add-on medications or to be referred for CBT.

NEWSLETTER: Will individuals who participate in this study be allowed to take part in your cognitive behavioral program for hoarding also?

SAXENAMAIDMENT: During the 12 week period of treatment with Paxil, study participants cannot receive any CBT. However, after they have completed the study, we frequently refer patients for CBT, either at UCLA or in the community.

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

SAXENAMAIDMENT: They should contact Karron Maidment RN, M.A. at (310) 794-7305 and say they are inquiring about the PET/Hoarding study.

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Dell, Timberland, Cisco, Chevron/Texaco, HP Corp., Gannett Corp., Washington Post, Lockheed-Martin, and many others.

A Review of "Bad Hair Life": A New Hair Pulling Documentary by Jennifer Raikes

Reviewed by Fred Penzel, Ph.D., Executive Director Western Suffolk Psychological Services Huntington, NY Member of the Scientific Advisory Boards of the Trichotillomania Learning Center and the OC Foundation

High-quality documentaries that depict the true nature of Obsessive-Compulsive Spectrum Disorders are extremely rare. This is particularly true of some of the less well-known ones. At long last, a filmmaker in the person of Jennifer Raikes has created one such illuminating video about trichotillomania (compulsive hair pulling), titled "Bad Hair Life." It shows this disorder in all its various dimensions and aspects in a way that has never been done before. Although it has been estimated that at least one percent of the population suffers from this problem, it remains virtually unknown to the general population. Even a large number of sufferers believe they are the only ones who do what they do.

It should be mentioned that Ms. Raikes is the President of the Board of Directors of the Trichotillomania Learning Center (TLC), based in Santa Cruz, California. She has also pulled her hair since childhood and is, therefore, in a unique position to communicate the experience of having this disorder in a way that only someone who has lived with it can. Films of this type run the risk of taking on a sensational sideshow quality; a trap that this one manages to avoid. The structure of the film is built around a countrywide odyssey that Ms. Raikes embarked upon, visiting various men, women, and children who live with trichotillomania. And a diverse group they are: a nun, a factory worker, a high school student, a kindergarten teacher, the founder of TLC (Christina Pearson), and an adolescent girl who also happens to have learning disabilities. We are taken into their homes, jobs, and daily life to see how it has affected each of them. Ms. Raikes respectfully allows each one to tell his/her story in his/her own way, without scripts or acting.

Woven throughout is Ms. Raikes' own story, told via voiceovers and family photos. This is no mere exercise in sentimentality, however. This film shows us everything - the sadness, the isolation, the regret, and the frustration of the sufferers and their families. It even shows us someone actively pulling out facial hairs in a rather uncomfortable close-up. I must admit to physically wincing with every hair pulled as I sat and watched this sequence.

While presenting us with these intimate vignettes of individuals, Ms. Raikes does not skimp on the larger context. A portion of the film is also devoted to a well-illustrated and at times amusing social history of hair and its role in social attractiveness and status

through the ages and across cultures. Watching clips of female French collaborators having their heads shaved as punishment certainly brings some of these points home.

"Bad Hair Life" is extremely comprehensive, including commentaries from some of the leading experts in the field of Trichotillomania treatment and research. They help to put what we are seeing in perspective and emphasize that we do not have all the answers. Ms. Raikes, together with her scientists and practitioners, tries hard to make the point that there is still so much we do not know about this mysterious behavior.

I personally found this film to be excellent in all aspects, with virtually nothing left out. It captures the essence of what the experience of hair pulling is all about, and how it impacts people's lives. I would have liked to see more information presented about treatment and recovery. But this would really have been impractical for a film of this type and would best be dealt with in another film. Perhaps Ms. Raikes will someday create another film that gives us some recovery stories and allows us to follow sufferers through successful treatment. One can only hope. It should be noted that Ms. Raikes labored for several years to raise every cent that went into funding this project. Films of this type are not cheap to produce, which, I suppose, is why we sadly have so few of them.

This is a well put-together film, with fascinating and high-quality content, a strong narrative voice, and excellent editing. I have only seen one other documentary about OC related disorders that I would rate on a par with "Bad Hair Life." That would be "Twitch and Shout," Lowell Handler's wonderful documentary about Tourette's Syndrome. I would recommend Ms. Raikes' film not only to trich sufferers, who would feel that their story has at last been told; but I would also recommend it to their families and friends to give them as close a sense of what this disorder is all about without actually having it. I would further recommend it to the many psychologists, psychiatrists, and other practitioners out there, whose professional training did not include information about disorders of this type.

I would just like to add that I attended the film's first public showing, and witnessed as it received a long standing ovation from what could be its potentially toughest audience - a group of over two hundred trich sufferers. I think this speaks for itself.

Dr. Penzel can be e-mailed at penzel@attglobal.net.

Bad Hair Life is available through www.fanlight.com/press.shtml or by calling (800) 937-4113.

Cognitive Therapy For OCD

(continued from page 1)

importance or significance on the mere presence of a thought? Many OCD sufferers believe that just because a thought is present, it must carry some importance. This is not necessarily true. Try this experiment. Allow yourself to be aware of all thoughts entering into your mind over the next three minutes. Some thoughts could be important and some may be totally random or nonsensical and not have any significant meaning. OCD makes a sufferer believe that all thoughts have equal importance. Related to this is the belief that thinking a thought is the same as doing an action; or the mere presence of a thought will result in an unwanted action or will cause an event to happen.

2) *Overestimation of threat/all-or-nothing thinking.* Do you tend to overestimate the actual probability or level of threat associated with a particular event? Do you catastrophize a situation, immediately conjuring up as a probability the worst-case scenario? Are you considering only information the OCD is trying to emphasize; magnifying this out of proportion while minimizing or disqualifying other evidence to the contrary? Do you think in terms of black-and-white or all-or-nothing without considering the grey area or steps in between?

3) *Difficulty with doubt and uncertainty.* Do you have a difficult time tolerating uncertainty? Doubt is a common symptom of OCD and frequently generates a great deal of distress when the OCD won't allow a situation to "feel right" or won't allow you to feel a comfortable degree of certainty about a particular thought or event. Observe your internal self-talk about having to sit with the discomfort of doubt and uncertainty. Do you wish for this discomfort to go away immediately?

4) *Overresponsibility.* Does the OCD influence your thinking by telling you to take complete responsibility for situations in which anyone else would not consider you responsible? Do you believe you have the power to prevent negative or catastrophic events from happening by doing mental or physical rituals? Do you excessively concern yourself with, or blame yourself for, a negative event which may or did happen?

5) *Reasoning/logic based on emotions.* Are your conclusions about a situation based more on your strong emotions and less on actual fact? Are you confusing a feeling as evidence of a fact because that's what the OCD is telling you? Do you say

to yourself "I'm feeling anxious; therefore, this situation must be dangerous" or "I'm feeling guilt; therefore, I must have done something bad?"

Once you're able to identify areas of unproductive thinking, what can you do? Talk back. Look at ways you can change your interpretation of an event. Look at ways you can change what you say to yourself in response to an unwanted intrusive obsession. Consider ways to reduce your emotional reactivity to OCD-triggering thoughts and situations based on the above patterns of thinking. While this might sound simple, it is not so easy or straightforward. You can't just talk away all your OCD. Nor can you talk away all feelings of doubt and uncertainty. But with creative brainstorming you may be able to identify cognitive strategies which will enhance your treatment outcome. CT is primarily a tool to supplement Exposure and Response Prevention work. CT can help you challenge the falsehoods the OCD is telling you. It can motivate you to stay in an exposure situation longer and/or work harder to resist rituals or avoidance behavior. It can help you learn to better tolerate doubt and uncertainty.

Here are four general questions to get you started in talking back to your unproductive thinking. Depending on your type of OCD, some avenues of questioning may work better than others. You will need to experiment with what works best for you. Consistent practice in using CT strategies is needed and it takes time to learn. Talk with your therapist about how to do this and whether this treatment strategy is right for you and your symptoms.

1. Identify your unproductive patterns of thinking.

* Ask: Where is the evidence that what the OCD is telling me is actually true? Try to estimate the actual probability of a feared situation happening. Remember to consider the probabilities of all the possible steps between your actions or thoughts and what you fear may happen. What is the evidence for and against your specific interpretation? Are you confusing thought with fact? Is your causal relationship logical?

* Even if internal self-talk appears logical and accurate, are the feared consequences really as awful or catastrophic as the OCD is trying to make them out to be? Reduce all-or-nothing thinking.

* Do a cost benefit analysis. Look at the time, energy, effort and general cost to

your quality of life by listening to what the OCD is telling you. Is the actual probability of a feared event worth this cost?

* What is the norm? How would someone without OCD do a particular task or how might they respond to an intrusive unwanted thought?

Now that you have a general idea on how to do cognitive therapy, let me offer some times when you should not use these strategies. First, beware when CT efforts turn into one big repetitive self-reassurance ritual. Are you trying too hard to convince yourself there is no evidence for the feared event? Are you using the CT to reassure yourself about a thought or situation so you don't have to sit with the doubt and uncertainty generated by it? Therapy for OCD, in part, involves learning to tolerate the discomfort of doubt and uncertainty. Are you trying to use the CT to give you clarity about a situation in an effort to get it to "feel right"? If so, throw the CT out the window for these OCD-triggering events and consult with your therapist on possible self-talk strategies that focus on how to better tolerate the experience of doubt, uncertainty and/or events not feeling right.

Second, are you doing a flooding type of ERP by facing your worst-case fears and thoughts? This may involve going into a previously avoided situation and deliberately thinking your worst fears or may involve writing out a script or recording on tape your most feared intrusive thoughts and situations? The way to reduce fears and anxieties is to face them. Facing feared situations, thoughts and images provides an opportunity for habituation and symptom reduction. Use of cognitive therapy strategies during flooding-style ERP tasks can dilute the intensity of the exposure task and thereby reduce potential for habituation gains.

Third, are you making a consistent effort to generate more productive self-talk but instead it feels like it is turning into an obsession? Do you just feel totally confused about what you should be doing and seem to be spending too much time trying to figure it out? Are you caught up in whether you are doing the CT correctly or perfectly? If so, you may want to put your use of CT on hold until you can discuss this with your therapist. CT should be productive. It's purpose is to help you do your ERP, not give you another item over which to obsess.

The goal of this article is to offer you a sampler of what CT is and its potential benefit in treatment. I hope it has also increased your awareness of when CT may interfere with treatment progress.

From The Foundation

(continued from page 1)

the VCR in Nashville. Thank goodness for cell phones, federal express and printers who not only deliver the NEWSLETTER on time, but also will search your office/stable until she finds the left-behind video. What was really bothering me wasn't the possibility of a blank screen at the Film Festival, but that Jeannette was threatening to make me cancel the order for the "old fashioned" popcorn maker if there weren't any films to show at the "Film Festival."

This year we decided to open registration on Thursday night. This made it a lot easier for everyone on Friday morning, despite the fact that I was a "no-show" at 5 a.m. I just want to reiterate here that it was a typo; I did not just willfully oversleep. I keep emphasizing that because no one appeared to believe me at the time. That's why I feel compelled to use my unrestricted access to the print media to present my side of the story. Mary and Leslie defended me on that one, I think: they told Jeannette, based on their past experience with me behind the Registration Desk, I would have been more of a hindrance than a help. So it was actually a blessing.

This year we had FERPs at the Conference. A "FERP" is a Exposure and Response Prevention Friend. Kathy Parrish, M.A., M.S., and Lori Kasmen, Ph.D., from the Anxiety and Agoraphobia Treatment Center in Pennsylvania, the same therapeutic community that invented the Virtual Camping Trip, introduced the FERPs.

The kids at the Conference learned about the FERPs at their Orientation meeting on Friday morning. Kathy and Lori brought their own FERPs as models and with the able support of Jennifer Waite-Wollenberg, an art therapist from Rogers Memorial Hospital and the volunteers, Rebecca Crane, Carla Ann Kenney and Melanie Napp, showed the kids how to make their own.

After being barred from the FERP-making session and being asked to leave the Adolescents and Young Adults Orientation because "I was way too old," Mary Grande, our events planner, dragged me off to the Affiliates Meeting that she had set up for representatives from our affiliates. This was another meeting that went well, despite my presence. Mary poked me whenever I drifted off the agenda, which was specifically, "Recruiting and Retaining Members." Gayle Frankel, the president of the Philadelphia Affiliate, generously shared with everyone what she had learned about increasing and retaining members from another organization. It should be noted here that scrupulosity does not apply when

you're "borrowing" information from another organization. Both Dr. Osborn and Dr. Ciarrocchi gave me a special dispensation for that.

Affiliate members who learned and shared a lot included: Gay Nightingale from Florida; Joy Kant, Greater Boston, Scott Granet and Mary Weinstein, San Francisco; Joan Kaylor and Andrea Schwartz, Western Pennsylvania; Ellen Sawyer and Tom Caveney, MetroChicago; Ina and Julian Spero and Allen Weg, Central New Jersey; and Bruce Hyman and Lisa Bertman-Pate who are hoping to start affiliates in south Florida and New Orleans, respectively.

There were over 80 presentations, workshops, seminars and support groups throughout the weekend. Five or six presentations at a time. Scheduling them was a total OCD nightmare. The biggest problem was that Dr. Jonathan Grayson was involved in every one of them. Or, at least it seemed that way. We had him performing back to back; and, I think, he even bilocated several times. But, he did manage to eek out enough time to do a book signing, even though his new book, "Freedom From Obsessive Compulsive Disorder," hadn't been printed yet. He signed flyers instead.

This year we had an entire room for the OCF Bookstore. It gave Bob and Mimi Doan, volunteers who have been managing the conference bookstore for five years, since 1999, a chance to spread out our wares and plenty of space for the 13 authors who were there to sign their new books, to meet with shoppers and answer their questions.

A personal aside and I know I've been warned by the Board of Directors about using this column to advance my own personal agenda, but I consider telling my side of the story to be a step toward establishing world peace. I did NOT unwrap and take a bite out of everyone of the candy bars that I was sent to purchase for the Virtual Camping Trip. They all just melted in strange bite-like configurations because of the heat. And, even if I did take a bite or two, I'm the one who trudged across what seemed like seven miles of hot melting asphalt to the Mall to buy the candy bars. I went because the staff said I was the only one wasn't doing something critical to the functioning of the Conference. I took that as tribute to my ability to delegate.

We were really fortunate to have Dr. Dennis Charney, chief of the Mood & Anxiety Disorders Research Program at the National Institute of Mental Health, as our keynote speaker. His achievements as an investigator and administrator are so

impressive that they awed Dr. Jenike into giving him a "no-joke" introduction. The only other person Dr. Jenike doesn't make fun of when he's doing an introduction is the eminent physician who signs his paycheck at MGH. We invited Dr. Charney to speak not only because he is one of the country's foremost researchers of mental illness, but because of his relationship to the OCF. Dr. Charney was the Principal Investigator in the medication trials at Yale that gave birth to the Foundation. We wanted to show him how far the Foundation had come from those raucous Saturday afternoons in the Nurses' Lounge on the Yale Neuroscience Unit.

This year we had two Centerpiece Seminars: one on Compulsive Hoarding chaired by Drs. Frost and Steketee that featured a panel discussion about how communities were responding to hoarding-related problems. The overwhelming response in the evaluation of this presentation was that it was excellent and that we needed more presentations on hoarding. Right after the presentation, there was a meeting of Foundation's Hoarding Task Force. The group, including clinicians, researchers, community activists, OCF staff and hoarders, met to discuss the content for the proposed Hoarding web page that we are going to add to the OCF website. Last December, the Causey Foundation, gave the OCF seed money to start a Hoarding web page. The plan is that the site will contain research and clinical articles on hoarding, as well as listings of community and treatment resources. It will be on-line this coming winter.

The other Centerpiece Seminar was on Recovery Avoidance. There was a general session and then the presenters, Dr. Alec Pollard and his colleagues from Saint Louis Behavioral Medicine Institute, broke out into groups, each of which focused on the avoidance issue from the respective points of view of the OCD sufferer, his family and clinicians involved in treating OCD. The seminar is an extension of the work the Saint Louis Group has been involved in with families for quite a while now. The group received a 2003 OCF Research Award for its work in this field. Their newly funded study is "The Effects of Brief Consultation to the Families of OCD Treatment Refusers: A Pilot Study." The Pollards, Alec and Heidi, wrote an article on this topic that was featured in the Summer 2002 issue of the OCD NEWSLETTER, "Someone I Care About Is Not Dealing With His OCD: What Can I Do About It?" We've been sending copies of it to people since it was in galley proofs.

Things went really well at this Conference so they kept telling me through the door to the "War Room." After the issue with the candy bars, it was decided by staff vote

(continued on page 13)

From the President

Dear Friends,

Over two years ago we formed an Education Task Force to address a need



voiced by so many of the parents of our Foundation. While the Foundation had developed a video program, "How to Recognize and Respond to OCD in the Classroom," which was aimed at the classroom

teacher, there was still the need of an efficient and informative manner in which to present this complex issue, as well as some additional practical information that would be helpful to school personnel. Two years ago in Denver at the 8th Annual OCF Conference, the Education Task Force which included parents, teachers, OCF board members, OCF staff, a student with OCD, a marketing professional, and a documentary producer, formally met and decided that a "step-by-step presentation manual" would be the best approach to providing a complete program for our parents' use in the schools.

The original program contained two very interesting and instructive videos and several helpful pamphlets on various aspects of OCD. Unfortunately, the parent-presenter, who wanted to educate their child's teachers about the effects of OCD on learning and classroom behavior, had to face the daunting task of preparing a presentation and putting on a program that would support and highlight the information provided in the videos. Luckily, for our children and, despite the time and effort it took, many parents and other interested individuals did produce such programs for use in the schools. Many of these individuals volunteered to be part of the Education Task Force. Their experiences in schools became the basis for the "Presenters' Manual."

It had been decided at the Education Task Force Meeting in Denver that a professional writer would be needed to draw together the information for presentation and develop an instructional format for the presentation manual. We found an experienced writer, Marlene Brill, who has an education background and knowledge of OCD and related disorders (we were lucky!). Marlene inter-

viewed Task Force members, Tamra Wulff, Karen Yuan, Bernie Bahr and Andrew Emmerman, for additional information about classroom issues as well as presentation issues. They also made time to review the first draft to make comments and suggestions. We also received help from Doctors Michael Jenike and Jonathan Grayson, who reviewed the pamphlets and shared their expertise on the nature and etiology of OCD and the effect and efficacy of medication and cognitive behavior therapy. The OCF staff contributed their editorial and design skills.

The result is a unique manual, containing a tightly written script that describes OCD, the effects that it has upon a child's ability to study and learn, as well as to socialize. It provides information not only on how a teacher can cope with OCD in the classroom, but also how the teacher can play a role in the student's recovery by working with the child's therapist and parents. The script is cued to slide transparencies that are part of the package. The program also includes handout material that can be copied and passed out to program attendees.

An important component of the original edition of "OCD in the Classroom" was a pamphlet written by Gail Adams, Ed.D., associate professor at the University of Illinois and member of the Metro Chicago OCF Affiliate, entitled "School Personnel: A Critical Link in the Identification, Assessment and Treatment of OCD in Children and Adolescents." This pamphlet deals with the pivotal role that teachers and other school personnel could play in a child's treatment and recovery. Dr. Adams tackles every topic of interest to educators who are dealing with a child with OCD from the impact of federal and state legislation to ways to deal with classmates' bullying. This past spring Dr. Adams updated the pamphlet; and it is part of our revised program.

There is also new packaging for the program. The design is the work of OCF staff member Leslie Capezzone; and we are all very proud of it. The entire program is contained in a cardboard box with pockets and compartments that can be folded and tucked together for a "ready to go anywhere" package.

And, I have saved the best part for last! We will be able to offer the entire program – three pamphlets: "Obsessive Compulsive Disorder in Children &

Adolescents," by Dr. Hugh F. Johnston and J. Jay Fruehling, M.A., along with the "Presenters' Manual" and "School Personnel: A Critical Link," two videos: "Jake's Story and the Kids' Panel" and "How to Recognize and Respond to OCD in School Age Children," transparencies, and the handout prototypes – for \$15.00 plus shipping and handling for OCF members, \$25.00 plus shipping and handling for non-OCF members for the first 500 we are producing. Later printings may cost more.

The original set was previously selling for \$50 (members) \$75 (non-members). We have been able to keep the cost of the first 500 copies of the new program low because of funding received from the Lupin Foundation and Edna and Bernie Bahr. Support for this project was further enhanced from the proceeds of our raffle at this year's Annual Conference. We sold \$4,251 worth of tickets, all of which went to producing the program because the Perakis Family Foundation again donated funds to cover the cost of raffle prizes and other expenses. On behalf of the Foundation, I would like to thank our generous donors as well as everyone of you who bought raffle tickets, as well as those who sold the tickets at the Conference, especially the Lancer Family – Irwin, Paula, Rob and Dena, and the Bahrs – Bernie and Edna.

If you have a school-aged child with OCD, or if you are just concerned about children with OCD, please give serious consideration to ordering one of our newly packaged programs and putting on this presentation at your local school for teachers and special education personnel to help them to help our children.

Best regards,

Janet Emmerman
President
OCF Board of Director

P.S. Please join me in thanking and congratulating our Conference staff, Patti Perkins, Jeannette Cole (Annual Conference Coordinator), Daisy Sanchez, Mary Grande, Leslie Capezzone, and Carole Ringuette, for the superb job that they all did in making the 10th Annual Conference in Nashville an excellent educational and supportive experience for attendees of all ages. The Board is extremely proud of their incredible efforts and successes!! Mark your calendars for a similar experience in Chicago July 23-25th, 2004.

From the Foundation

(continued from page 11)

that I guard the empty shipping boxes while they ran the Conference. However, there was one *small* problem that almost derailed our fundraising efforts for the Education Task Force and landed me in jail. That is one problem above and beyond what happened when the DJ played the "Chicken Dance" song at the Reception.

Did anyone know that gambling is illegal in Tennessee and that raffles are considered "gambling" under Tennessee law? Well, surprise. It is. But we didn't know until late Friday afternoon, well after we had sent our enforcers/sales personnel out to sell raffle tickets, a shakedown activity we have engaged in since the Seventh Annual Conference. That's when someone from the hotel staff noticed that we were "engaged in illegal gaming activities." Once alerted, they informed us that raffles were "illegal" and we could be arrested if the "revenueurs" found out. At that point, Jeannette let them know that for all "arrest type" purposes I was in charge.

So, we hastily rounded up all the prizes, all the promoters, and all the tickets; retreated to our "War Room" and invented Plan B. We decided that we would make an announcement at the Keynote Address, telling everyone that they could turn in their ticket stubs and we'd return their money. We were not happy because we had earmarked the raffle proceeds for underwriting the cost for the revision of the "OCD in the Classroom" program. Some of us even thought bad thoughts about the hotel staff and the Tennessee legislature.

But, someone on the hotel staff did some heavy obsessing over the situation and came up with a very twisted solution that made the lawyer in me all tingly. You can't sell raffle tickets under Tennessee law, but you can give them away when someone buys something else, like, for instance, a piece of candy. Because of the pall of suspicion still clinging to me over the alleged nibbles in the Camping Trip candy bars, Jeannette went off and purchased every piece of penny candy available within walking distance. Some attendees were so hypoglycemic that "M&M's" went for \$20.00 and we made \$4,251.00 for the Education Task Force. Here, I'd like to take a breath and thank the Perakis Family Foundation for contributing the money with which we purchased the raffle prizes and to thank Irwin and Paula Lancer for running the raffle.

On Saturday afternoon, we held the organizational meeting of the OCF Young Leaders group. They let me attend even though it's been eons since I was young. The idea for

forming a group for young people with OCF with the aim of training them for leadership positions with the Foundation actually was Elyse Monti's. She's a senior in high school who has taken control of her own OCD and wanted to help others overcome their problems with OCD.

We handed out flyers announcing the meeting and a lot of young adults came. We didn't even have to offer them snacks to get them to come. The most amazing thing about the meeting was the way these young adults interacted. When I was in high school; hell when I was in law school, I never attended a meeting or was involved in an extracurricular activity where the members of the group, mostly strangers until the day before, were not only able to talk about personal issues, such as, their own unique experiences with OCD, but able to offer really good advice and help to one another. This was on top of their critiquing the content of the Conference seminars and workshops set up for them and proposing activities and seminar topics for next year's Conference. They were awesome. They will do an incredible job when it's time for them to take over the Foundation.

On the advice of my union rep, I will have nothing to say about my performance on the dance floor at the Reception. He says there is an aesthetics sensibility clause in my contract and that my partaking in the "Chicken Dance" violated it.

After chairing the Scientific Advisory Board's meeting and taking a truncated swim in the hotel pool (it seems, he thought the meeting started earlier than it did), Dr. Jenike opened the Third Annual Town Meeting. This year's topic was "Participating in Research Trials." Except for me, see paragraph 1 on page 1, we had a very distinguished panel: Dr. Michael Jenike, Dr. Gerry Nestadt, Dr. Sabine Wilhelm, Dr. Jonathan Abramowitz, and Dr. Sanjaya Saxena, who talked about their own research programs and acknowledged that their success depended totally on the willingness of people with OCD and their families to participate. Participants from the audience, who stepped up to the mics, shared their experiences of taking part in various trials. They also shared their fears and misgivings, which the panel addressed openly and honestly. It was a great way to end the Conference: with hope and with the knowledge that we all had something we could do to help achieve our goal of "Effective Treatment for Everyone with OCD."

Thanks for the memories.
Ciao! See you in Chicago in 2004!

Patricia Perkins

My First Time

By Joshua Goldsmith

Editor's Note: Josh volunteered at OCF headquarters this summer as an intern as well as doing a presentation with Dr. Steven Phillipson at the 10th Annual Conference.

I had very little idea what to expect when I arrived in Nashville to be a presenter at the OCF Annual Conference. I knew that I was a person diagnosed with Obsessive Compulsive Personality Disorder (along with Obsessive Compulsive Disorder) and that I was going to be speaking from personal experience along side Dr. Steven Phillipson, the Clinical Director of the Center for Cognitive-Behavioral Psychotherapy in New York. Other than the fact that I live with the disorder, I had no reason to believe that I was a qualified speaker or that my presentation would be impressive in any way. As I saw it, I was going to be a speaker among doctors, all of whom were going to be more skilled (or at least more experienced) in articulating the intricate nature of obsessive compulsive issues than I. Who am I? I'm a 21 year-old art history major. What was I doing in Nashville? Good question.

I was so obsessive while we were giving our presentation - with regard to my exact choice of words, whether or not I was saying the "right" thing, etc. - that I became increasingly certain that I had blown it as time elapsed in our one hour and forty-five minute talk. All I could think about as I sat up on stage in front of roughly a hundred people was how much I was going to regret and obsess over every single word that came out of my mouth. And this would have been the case. But, somehow, I was saved. The moment the presentation ended, I was swarmed with people who were telling me how much they enjoyed my talk, how much they related to it, how good it was to hear someone talk about experiences similar to their own, and on, and on, and on. It was a classic example of a situation that I had construed to be a complete failure that was interpreted by those around me as a tremendous success.

Generally, however, such positive reinforcement does not absolve me of the guilt I feel for making any perceived "mistakes" or free me from obsessing over the "mistakes" and trying to correct (or justify) them in my mind. At the OCF Conference though, I received such positive feedback from those who attended my presentation that I could literally let go of my imperfections in a way that I really struggle to in daily life. Positive feedback from my professors at college has never freed me from

My First Time

(continued from page 13)

agonizing over the slightest perceived imperfection. A favorite activity of mine is scrutinizing imperfections on tests and papers that have already been handed back to me with a grade of "A." So why would my presentation at the Conference be any different? I didn't see how it could be. I thought that I was setting myself up for disappointment and months of obsessing over the mistakes that kept my presentation from going "perfectly," even if I were to receive the kind of positive feedback that I did. But something ended up making this case different from any other I have experienced in my life.

Whatever I said in that room in Nashville, however imperfect I'm sure it was, managed to really connect with a lot of people. Maybe a lot of other people thought my presentation was an absolute waste of their time, but that didn't seem to matter. Something I said resonated powerfully with certain members of the audience; and that was enough for me to consider my presentation a success. Not a word of my presentation was scripted. My delivery was not polished (I have very limited public speaking experience). But people went out of their way to come up to me for the rest of the weekend and tell me how much they loved it – for exactly that reason. I was not all that informative; I did not provide the audience any profound revelations; and yet a lot of people seemed to find it a uniquely important presentation. As one person said to me, there was a "humanity" to my talk that really set it apart. That is why I am writing this article. I think that the "humanity" that connected with the people in my presentation is something that can only be provided by someone who is living with a particular condition. Doctors and experts are great, but this is the territory where they must step aside and let the patients do the talking. All I did was get up in front of an audience and talk, a bit incoherently, about myself and life with my condition. It was unsettling to deliver a talk with so little structure or direction. But, I think that is precisely what made it so effective. I offered no conclusions; I just talked straight from the heart. For many of you with OCD or OCPD, getting up in front of a lot of people and just talking about yourself is a risky thing to do. It certainly was for me. But it ended up being a rewarding experience for those who attended my presentation and a rewarding experience for me. I urge more OCD sufferers to take a similar risk, and, like me, experience the beauty of shedding light on your own condition, which will, ultimately, help you.

My OCD Notebook

Introductory Five-Step Guide for Doing Self-Directed E&RP

By Lisa Jo Bertman-Pate, Ph.D.

Tulane University School of Medicine

WHAT IS EXPOSURE AND RESPONSE PREVENTION?

Exposure and Response Prevention (E&RP) is a behavioral technique that is most effective for treating OCD symptoms when combined with medication. E&RP has two components: 1) "Exposure" involves confronting fears; and 2) "Response Prevention" involves not engaging in the response that makes you feel more comfortable. The goal of E&RP is habituation. Habituation refers to getting used to something that formerly produced a very strong emotional response. It is not enough to do just exposure or just response prevention; you must do both in order to experience habituation.

WHERE DO I BEGIN?

Below are five steps to take when starting E&RP.

1. Write out a complete list of situations, thoughts, images, impulses that make you anxious or uncomfortable (call this your OBSESSION LIST). Examples: Thoughts that I hit someone while driving; thoughts about shaking hands with others.
2. Write out complete list of all the things you do to reduce or help manage your anxiety (call this your COMPULSION or RITUAL LIST). Examples: Checking oven to make sure it's off; washing hands after touching certain items that are "dirty;" repeating movements; replacing a bad thought with a good thought.
3. Write out complete list of all the things you completely avoid because they make you anxious (call this your AVOIDANCE LIST). Examples: Trying on clothes in department stores; driving; doing laundry; stepping on cracks.
4. Rank each item on your COMPULSION and AVOIDANCE LISTS using a SUDS (Subjective Units of Distress Scale). This is a 10 point scale where 1 = no anxiety, calm, cool and collected and 10 = worst anxiety ever, panic attack. Rank each item using what you anticipate your SUDS would be if you were asked to RESIST doing the ritual or TO DO what you usually avoid doing. Examples: If you check the locks five times before going to bed or you wash your hands after putting your laundry in the wash, record what you think your SUDS would be if you did not do these rituals. Or if you avoid sitting on the floor in a public place or handling dirty laundry, record what you think your SUDS would be if you were to do these things. BE SURE you don't rank all the items 10 even though the thought of all these things may be very distressing to you. If you have a variety of rankings from 1-10, you will be in a better position to begin E&RP.

5. Generate a fear hierarchy by recording the items you ranked from lowest to highest. Set aside two hours for E&RP. Begin with the lowest item on your fear hierarchy. Expose yourself to the trigger and follow the directions labeled "DON'T" under the "Special Tips Regarding What Not to do During E&RP" Section below. Throughout the remainder of the day, you should follow the suggestions outlined in the word "Please" in the "Special Tips for Time Outside E&RP" below. Once you have experienced habituation to the lowest item, move to the next item, and so on....

SPECIAL TIPS REGARDING WHAT NOT TO DO DURING E&RP

DON'T

* DISTRACT

Distraction is just another way to avoid anxiety and won't allow you to habituate to your anxiety; focus on your anxiety and the exposure task you are doing.

* OVEREXPOSE YOURSELF

Sometimes people expose themselves to too much during an exposure session which can be counterproductive. Once your SUDS reaches an "8" or "9" you should not be exposing yourself to anything else until your anxiety comes down.

* NEED RITUALS TO REDUCE ANXIETY

Resist rituals and you will learn that you do not need to do rituals to reduce your anxiety. Your anxiety/discomfort will abate naturally within a period of time (usually two hours).

* TAKE ANTI-ANXIETY MEDICATIONS OR USE RELAXATION TECHNIQUES

As mentions above in the "Distract" Section, it is important to focus on the anxiety so that you do not attribute your gradual reduction in anxiety to something else. If you take an anti-anxiety medication or use relaxation techniques during E&RP, you will attribute your reduction in anxiety to these things and will continue to feel uncomfortable with the idea that you can bring your anxiety down without doing rituals or anything else.

SPECIAL TIPS FOR TIME OUTSIDE E&RP (throughout the rest of the day)

PLEASE

Plan pleasant activities daily

Learn Relaxation Techniques

Exercise

Adopt Coping Statements

Stay Busy

Eliminate Rituals/Avoidance Behavior

Whenever Possible

News of Affiliates, Support Groups and Friends of the Foundation

(continued from page 2)

The money raised will support the OCFMC's active agenda, which includes consumer education and support; professional education; public awareness; mental health advocacy; and support for scientific research.

FOURTH ANNUAL CONFERENCE FOR THE NEW JERSEY AFFILIATE OF THE OC FOUNDATION

The New Jersey Affiliate of the Obsessive Compulsive Foundation presents its Fourth Annual Conference. Dr. H. Blair Simpson will speak about "OCD: Biological Basis and Pharmacotherapy Treatment." There will also be an "Ask the Experts" Panel with Drs. Karen Landsman, Joseph Springer and Allen Weg. The Conference is scheduled for Sunday, October 26, 2003 at the Somerset Marriott in Somerset, NJ. For more information or to register, call Ina Spero at 732-828-0099.

LONG ISLANDERS HOLD FOURTH ANNUAL PICNIC

By Fred Penzel, Ph.D.
Western Suffolk Psychological Services
Huntington, NY

This last June, "Long Islanders Against OCD" held its fourth annual Fundraising Picnic at Eisenhower Park in East Meadow, New York. We like to think of our group as an "unaffiliated" affiliate of the OCF. Having had an unusually rainy spring, the Sunday we chose for our event was unfortunately no exception. The day was heavily overcast and rain threatened to drench us at any moment. The threatening skies cut our usually good attendance to half; but a group of very determined people showed up anyway, ready to support the event. We have always been fortunate to have a core of loyal people who care. Between our admission fees and the sale of raffle tickets, we were still able to make a donation to the OCF Research Fund. While this was not as large a sum as we had hoped to raise, it left us more determined to put a greater effort into next year's event and to remember to pray for sunshine as part of our planning effort.

What began four years ago as an experiment is becoming an annual tradition! We, on Long Island, challenge all of you out there to do in your own areas what we have done. You don't even need a big organization to do it. Nor do you need a lot of organizers. For some people, it is a

rare chance to get out and socialize in a friendly and understanding environment. In any event, all you need is your lunch, a free afternoon and the desire to help out. A plus would be sunshine. If you want more information, feel free to call me at (631) 351-1729.

AUDIOTAPE HOMESTUDY PROGRAMS AVAILABLE

HomEd offers audiotape CE homestudy programs accredited by NBCC, NAADC and NASW. Newest of our 35+ programs are: Compulsive Hoarding, by Randy Frost, Ph.D.; Advanced Techniques for OCD, by Gail Steketee, Ph.D.; Internet-Enabled Addictions by David Greenfield, Ph.D. and Group Psychotherapy by Scott Rutan, Ph.D. For more information call toll free: 866-473-8101 x13 or visit our website: www.naswma.org/homed. HomEd is produced by NASW, Massachusetts Chapter.

OBSESSIVE COMPULSIVE AND RELATED DISORDERS LES GRODBERG MEMORIAL LECTURE SERIES 2003 - 2004

The lectures will be held at the De Marneffe Cafeteria Building (Room 132), McLean Hospital, Belmont, MA.

The OCF of Greater Boston, in conjunction with McLean Hospital, presents this series of preeminent speakers in the field of OCD and related disorders. An informal social is held from 6:30 pm - 7:00 pm. Each presentation begins at 7:00 pm.

September 9, 2003

What is Obsessive-Compulsive Disorder?

Deb Osgood-Hynes, Psy.D
MGH/OCD Institute

October 7, 2003

The Nuts and Bolts of Exposure and Response Prevention (E&RP)

Jeff Szymanski, Ph.D.
MGH-OCD Institute

November 4, 2003

Naturalistic Treatment for OCD

David Mischoulon, M.D.
Partners Healthcare

December 2, 2003

Neuro-Imaging Research in OCD

Scott Rauch, M.D.
Mass General Hospital

January 6, 2004

Behavioral Treatment for Pediatric Trichotillomania

Susan Sprich, Ph.D.
Mass General Hospital

February 3, 2004

Scrupulosity

Leslie Shapiro, LICSW
MGH-OCD Institute

March 2, 2004

Family Coaching for OCD

Laura Ferrer, Ph.D.
McLean Hospital

April 6, 2004

Educating Educators: How to Manage OCD in the Classroom

Kathleen Trainor, Ph.D.
McLean Hospital

May 4, 2004

OCD and ADD

Jim Claiborn, Ph.D.
Manchester Counseling Center

June 1, 2004

Using Goal Setting as a Strategy in the Treatment of OCD

Denise Egan Stack, LMHC
MGH-OCD Institute

Following each speaker presentation, there are several free self-help groups open to the public. For information on support groups, please contact Denise Egan Stack at 617-855-2252. The groups will begin at 8:00 pm and run until approximately 9:30 pm. in rooms 114, 115, 117 and 118. The identity of participants and content of group discussion must remain confidential. Furthermore, if desired, you may remain anonymous. We remind participants to be open and supportive to the views of all those who take part in the support groups.

NOTE: All lectures are subject to change without notice.

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