



PATIENT – THERAPIST TEAM KNOCKS OUT OCD

By Jerry Bubrick, Ph.D.
Upper Montclair, New Jersey, and
Dan P.

Dan’s Story

Sometime in late October, 2004, the hell that became my life began. I was driving home from school one day and started to worry that I had possibly hit someone. I was not able to dismiss the thought. The worry of hitting people continued the day after, and the next day, and it quickly consumed me. I literally could not drive five feet without worrying that I had hit someone. I feared driving and wanted my friends to drive anytime we went out. Although my worries were paralyzing me, I had no idea how much worse life was going to get.

After a few weeks of keeping it to myself, I finally told my parents and they brought me to a therapist. I saw

her for a month, but the problem continued and got worse. My fears of hitting people magnified in scope and creativity. I eventually feared that not only was I hitting people, I was also concealing their bodies.

As time progressed the fears got worse and worse. I started to worry that I was intentionally hitting people and perhaps even aiming for them. I worried that I was a murderer and I wanted to kill people. My “insanity” raged on, and I sat in my car and cried every day before driving to school. Once I arrived at school, I worried about how many people I had hit on the way over. The guilt of possibly hitting and killing someone’s mother, father or child was killing me. I continued therapy, but the problem persisted.

As my fears intensified, I started worrying about the worst thing I could imag-

(continued on page 12)

Good News From the Federal Courts

By Travis R. Hollifield, Esq.

In a new opinion that was released recently, *Billings v. UNUM*, the 11th Circuit (which is the appeals court that oversees all federal courts in Florida, Georgia, and Alabama) has judicially recognized for the first time that OCD is a condition with physical or organic causation. This “elevates” the legal status of the condition which some courts, employers, and insurers have heretofore believed to be little more than a severe neurosis or eccentricity.

In sum, this suit is about the denial of an insurance claim where the appeals court upheld a lower court decision that permitted an insured to obtain benefits under an insurance policy where the benefits had been initially denied by the insurance company as an exclusion for a “mental illness.” The court found that because the term “mental illness” was not expressly defined in the policy as including conditions such as OCD that have “mental” symptoms but that have an objectively measurable or identifiable physical cause versus purely “mental” conditions that do not have such objective causation, then the insurance company could not rely on the exclusion to the detriment of the insured.

(continued on page 7)

OC FOUNDATION SEEKS PROPOSALS FOR THE 2007 OCF RESEARCH AWARDS

The OC Foundation has issued its “Call for Proposals” for the 2007 OCF Research Awards. “This year we are hoping to attract proposals from researchers who are working in the OCD field and whose research may ultimately lead to more effective treatments for OCD,” said OCF executive director, Patricia Perkins, when announcing the “Call.”

In commenting on the “Call,” Dr. Michael Jenike, chairman of the OCF’s Scientific Advisory Board and director of the OCD Institute, noted that “research is the cornerstone to understanding more about OCD and OC spectrum disorders. The Foundation wants to attract young investigators to the field of OCD research.” According to Dr. Jenike, the OCF seeks to underwrite preliminary stud-

ies that will give researchers sufficient scientific data so that they become eligible for career research awards from the National Institute of Mental Health.

Research areas the OCF wishes to support, according to Ms. Perkins, include studies on the brain, its chemistry, structure, and functioning; neurobiology; the genetics of OCD; its epidemiology; its economic effects on sufferers, their families and the national economy, the pathophysiology of OCD; cognitive and behavioral aspects of OCD; cognitive-behavioral treatment mechanisms; and all aspects of OCD and the OC spectrum disorders that could lead to prevention and treatment advances.

(continued on page 5)

In This Issue

- Gosh, I Dislike the Way I Look! p. 3
- OCD and Anorexia p. 4
- Research Digest p. 6
- An Interview with Dr. Feusner p. 8
- A Consumer’s Thoughts on CBT p. 10
- The Role of Mindfulness p. 13
- An Interview with Dr. Wilson p. 14

Bulletin Board

DO YOU HAVE OBSESSIVE-COMPULSIVE DISORDER? DO YOU STILL HAVE SYMPTOMS?

We are conducting a research study of an investigational supplemental agent for individuals age 18-65, who have been treated for obsessive compulsive disorder but still have symptoms. All study-related procedures and evaluations are provided at no expense. Reimbursement for participation available. For more information and to find out if you are eligible for this study, please call:

Melissa Benedict (845) 398-5525

The Nathan Kline Institute
Outpatient Research Program
Orangeburg, NY

This study is funded by the OCF Research Fund.

OCD RESEARCH AT THE U.S.-MEXICO BORDER

The College of Health Sciences at the University of Texas at El Paso is conducting research about OCD in relation to culture and ethnicity.

Are you?

- Suffering from OCD (diagnosed or not)
- Of Mexican or Mexican-American background
- Over age 18
- Living in the El Paso, TX - Ciudad Juarez, Chih. (Mexico) border area

We have a one-time confidential interview that lasts about 40-60 minutes. We will ask you about quality of life, symptoms, availability of treatment, culture, etc. We provide a \$25 gift certificate in compensation for your time.

Contact Oriana Perez at (915)747-8317 or at operez@utep.edu, or Dr. Tom Olson at (915) 747-7246 or at toolson@utep.edu to schedule an interview.

ARIPIPRAZOLE AUGMENTATION OF SEROTONIN REUPTAKE INHIBITORS FOR OBSESSIVE-COMPULSIVE DISORDER (UCLA)

Alexander Bystritsky, M.D., Ph.D., Principal Investigator, and Jamie Feusner, M.D., Co-investigator.

Serotonin reuptake inhibitors (SRIs) are the first-line medication treatment for obsessive compulsive disorder (OCD). Approximately 43-60% of those treated with SRIs alone will have a response.

With such a modest response rate and relatively low average reduction of symptoms (23-43%), additional medications are often needed in the treatment of OCD as most will fall into the categories of either "non-responder" or "partial-responder."

Several studies have shown benefit from adding medications called atypical neuroleptics to SRIs in people with OCD who have not responded to SRIs alone. (Atypical neuroleptics are medications which block the brain chemicals dopamine and serotonin, and include aripiprazole (Abilify), olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), and ziprasidone (Geodon).

In this study we are investigating augmentation of an SRI with the atypical antipsychotic aripiprazole (Abilify) in a group of OCD patients, whether or not they are "non-responders." This will allow us to determine both the effects of aripiprazole and whether the combination of an atypical antipsychotic and an SRI produces a more robust improvement in a broader OCD population than an SRI alone. Such information may significantly impact the standard of clinical care for OCD patients.

Subjects in this study will randomly be assigned to receive either aripiprazole (Abilify) or placebo in addition to their existing SRI medication for 18 weeks. Subjects will be evaluated every 2 weeks, and doses will be increased as tolerated and as needed. After the 18 weeks subjects will be assisted in finding referrals for continuing their treatment if effective, or finding other forms of treatment. The study medication will be provided free-of-charge, and subjects will be paid for their participation. If you are interested in participating in the study, or finding out more about it, please call: (310) 794-1038. *This study is funded by the OCF Research Fund.*

NAMENDA (MEMANTINE HCL) FOR THE TREATMENT OF OCD AND GAD (UCLA)

The goal of the study is to evaluate how a new drug with an innovative mechanism of action (decreasing glutamate in the brain) affects anxiety. We offer to participants a free research evaluation of anxiety. This study is 12 weeks and includes 5 visits. The first 4 visits occur every other week and the final visit occurs one month thereafter. Namenda is dispensed at Visit 1 and titrated to a maximum daily dose of 20 mg by Visit 3. Compensation is \$15/visit and UCLA parking vouchers will be provided. Namenda is an FDA approved medication, but not for the treatment of GAD. If you are interested in participating in the study or finding

out more about it please call: (310) 794-1038.

PARENTS OF ADULT CHILDREN WITH OCD LIVING IN SOUTHERN CALIFORNIA

I am a parent of a 43 year old currently in therapy and being treated for OCD and hoarding. I believe there are others like me who may be interested in starting a Parent Support Group to meet on a regular basis (perhaps once a month) in the southern California area. If you are interested in joining me and helping to decide when and where to meet and how often, please call me at (310) 475-8077 or email me at turk.porter@verizon.net. I hope to hear from many who need the support and help from others as I do. Sydney.

(continued on page 17)

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

Obsessive Compulsive Foundation, Inc.

Phone: (203) 401-2070

Fax: (203) 401-2076

E-mail: info@ocfoundation.org

Web site: www.ocfoundation.org

Joy Kant, President,

Board of Directors

Patricia B. Perkins, J.D.,

Executive Director/Newsletter Editor

Michael Jenike, M.D., Chairperson,

Scientific Advisory Board

The Obsessive Compulsive Foundation (OCF) is a not-for-profit organization. Its mission is to increase research into, treatment for and understanding of obsessive compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference, web site, training programs for mental health professionals, annual research awards, affiliates and support groups throughout the United States and Canada. The OCF also sends out Info Packets and Referral Lists to people with OCD, and sells books and pamphlets through the OCF bookstore.

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, products or treatments mentioned with your treatment provider.

GOSH, I DISLIKE THE WAY I LOOK!

By Fugen Neziroglu, Ph.D.

Alicia Slavis, Ph.D.

Bio-Behavioral Institute, Great Neck, NY

Sarah* is a 15-year-old who was teased about her skinny legs and freckles as a young child. As a youngster, she had been hurt but never showed it; and everyone thought she had forgotten about it. At 15 she looks at the mirror constantly to check out her face and legs. She cannot stop thinking about how she would look with "smooth skin." Sarah cannot stand her appearance and is constantly comparing herself to other girls in school.

She wants to have the face of Danielle who sits next to her in math class. She has gotten her mother for dermabrasion for a birthday gift; and although her parents are against it and do not think she needs it, they are thinking of agreeing to it. They will do anything to have her stop obsessing about her complexion. They have already been to several dermatologists and Sarah has used various creams; but Sarah is still very dissatisfied with her appearance. She spends way too much time mirror checking and asking for reassurance from her parents about her face.

Sarah is preoccupied with her legs as well but not to the same degree. She seems better able to camouflage her legs by wearing baggy sweat pants. The other day she was unable to wear a dress that she loved because she could not stand her legs (they do not seem skinny to anyone else). Often Sarah is late to school because she cannot find something that she feels comfortable in and it takes her a long time putting on foundation and cover-ups and getting her face to look just right.

Lenny* at age 13 had a few pimples and for the past 8 months he has been upset over pimples, bumps on the face and its redness. He doesn't like to go to gym because he may turn red which would make him look ugly and/or he may develop pimples from sweating. It started with gym. But then, as the weather got hot and there was no air conditioning in the school, he refused to go.

He was too embarrassed to tell his parents what was bothering him so he made up headaches, stomachaches and never seemed to feel quite right. He started avoiding friends and would make up excuses when they called or came by. Initially, he was going out at night but then that became too difficult as well. He complained to his parents about the pimples. Because he was "a typical teenager" who wanted to be liked by everyone, they thought nothing of it and took him from one dermatologist to the next. Lenny was told what products to use and given instructions on how to keep his skin in beautiful condition. Unbeknownst to the dermatologist and his parents, these precise, compulsive instructions made Lenny worse and eventually he stopped seeing his friends and did not return to school.

Lorie* at age 11 became obsessed with her thin lips. She heard her mother talking to her aunt about someone who looked awful with those "thin lips" and from that day on she could not stop looking at her own lips. She tried pulling on

her lips, wore lipstick, gloss and, in fact, tried keeping her mouth in a particular way to make her lips look fuller. Actually she tried to concentrate and have her lower lip turned downwards. When that became too difficult and she did not get the results she wanted, she just hid her lips with her hand. Lorie, even at such a young age, would carry a mirror with her and keep checking her lips. She asked her mother if she could go for the type of surgery that she read about in "People" magazine. At first her mother did not know what she was talking about; but she then realized that Lorie was really distraught over her appearance. Lorie could think of nothing else but her lips. She no longer wanted to talk on the phone to her friends or have them come over. She kept comparing herself to people on TV, in magazines, and to her friends. This made her more and more depressed.

What do all of these teens have in common? Although they may seem different on the surface, Sarah, Lenny and Lorie all have Body Dysmorphic Disorder, also known as BDD.

Being concerned with one's appearance is extremely common. Many of us dedicate a lot of effort to look a certain way, whether it's spending time at the gym, buying new clothes, or styling our hair. Furthermore, most of us would admit to disliking or wanting to improve some aspect of how we look. This is especially true during adolescence, particularly early adolescence. So what distinguishes this universal concern with one's outward appearance from a diagnosis of BDD?

Body image, like many things, can be thought of as falling along a continuum. It is the intensity, duration, and frequency of one's dissatisfaction with one's appearance and the anxiety, stress, and impairment in personal, social, and occupational functioning, which it causes, that distinguishes BDD from normal concerns about appearance. According to the DSM IV, to receive a diagnosis of Body Dysmorphic Disorder the following criteria must be met:

- 1) Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
- 2) The preoccupation causes clinically significant distress or impairment in functioning.
- 3) The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa).

As the definition states, people with BDD experience more concern about their appearance than their contemporaries do. They don't just experience an isolated thought about how they look; they actually obsess about their appearance. They think obsessively about a slight or imagined physical flaw. BDD comes in many forms and varies from one person to the next. The most commonly affected areas of the body are facial features, including wrinkles, scars, acne, redness, paleness, excessive facial hair, size, shape, or asymmetry of any facial features. Other body parts affected are

the genitals, breasts, buttocks, abdomen, hands/feet, and shoulders/back. Although, almost any body part could be the source of excessive preoccupation.

The severity of BDD also falls along a continuum. Some with milder BDD can live relatively normal lives, while severe cases of BDD can be life-threatening. The preoccupation with a flaw can lead to behaviors, such as, frequently checking oneself in the mirror, seeking reassurance from others about one's appearance, avoidance of usual activities, camouflaging, skin picking, and even cosmetic surgery. BDD often occurs with Obsessive Compulsive Disorder, Depression, and Social Anxiety.

So where can you turn for help for BDD?

Current treatments for BDD include psychopharmacological treatment, exposure and response prevention, cognitive therapy, support groups, and family intervention.

Exposure and response prevention is a form of cognitive-behavioral therapy that has been found to be very useful with BDD. It is the same form of therapy proven effective with OCD. Exposure refers to exposing one's defect in feared or avoided situations. This begins with the creation of a hierarchy of feared situations. Common distressing situations for those with BDD often involve mirrors, shopping for clothes, crowded situations with little personal space, and bright lighting. In conducting exposure exercises, a sufferer gradually exposes him/herself to the area of concern, working from situations that cause low distress up to those causing a lot of anxiety. Use of make-up, clothes, etc. to highlight or exaggerate a defect paired with gradual exposure is another step to this treatment. The idea behind this is that with enough exposure, the anxiety that you experience in a situation will diminish gradually. The second piece of response prevention refers to not performing compulsive behaviors. So, for example, if the compulsive behavior involves checking mirrors, a person with BDD may initially be asked to cover up all mirrors in his/her home.

Cognitive therapy teaches people to change their thoughts and thereby their feelings in a given situation. It is used to address faulty beliefs that one has regarding his/her appearance. Examples of distortions that may be seen in those with BDD include: "I need to be perfect," "If I looked better, my whole life would be better," and "If my appearance is defective, then I am inadequate and worthless." Cognitive therapy also shows promise in lessening strong beliefs about one's fears known as overvalued ideation. Targeting the value placed on appearance may also be an important step in preventing relapse.

Family involvement may be another step in treatment. When families are educated about BDD, they can be brought in to provide coaching for ERP exercises. Helping family members to reduce the frequency of giving reassurance or to change their accommodating styles can also be very helpful.

* The names of patients in this article have been changed to protect their privacy.

OCD AND ANOREXIA

By Eda Gorbis, Ph.D., MFT
Director, Westwood Institute for Anxiety
Disorders, Inc.
Los Angeles, CA

Jenny C. Yip, Psy.D.
Director of Education, Westwood Institute for
Anxiety Disorders, Inc.
Los Angeles, CA

Obsessive compulsive disorder (OCD) is the most common anxiety disorder, and it occurs in 40% of people suffering from anorexia nervosa (Kaye et al., 2004). Both disorders share many phenomenological similarities. The fears and obsessions of people with anorexia nervosa are similar to the obsessions that people with OCD experience. While the anorexic fears gaining weight and becoming obese, the person with OCD may fear ingesting food that is contaminated with germs and bacteria and becoming sick. The compulsive behaviors exhibited by anorexics include excessive dieting, over-exercising, repeatedly evaluating themselves in mirrors, and stereotypical weight checking. Food-related rituals, such as cutting food into tiny pieces, are characteristic of both anorexia and OCD. For anorexics, compulsions serve to relieve tension and the fear of gaining weight. Anorexics also take part in ritualistic habits in an attempt to control weight gain.

The personality of individuals with OCD and anorexia is characterized as stereotypically rigid, ritualistic, perfectionistic, and meticulous. According to Murphy et al. (2001), individuals who had a lifetime anxiety disorder diagnosis with an active eating disorder tended to have the highest scores in the categories of anxiety, harm avoidance, perfectionism, and obsessiveness. Anorexics also have distorted body images similar to body dysmorphic disorder (BDD) in the obsessive-compulsive spectrum.

The preoccupation with food found in anorexics depicts the intrinsic obsessive nature of the eating disorder. There is a persistent preoccupation with food in a concrete way in the form of involuntary ruminative calorie counting and mental imaging of food, which is experienced as out of the individual's control (Rothenberg, 1990). Along with an obsession with food, there is also a focus on control, which is a core element in OCD.

In addition to these common symptoms, there are biological similarities as well, since serotonin dysfunction has been implicated as one of the possible causes of OCD and anorexia nervosa (Hsu, Kaye & Weltsin, 1993). These factors have led many investigators to study the relationship between anorexia and OCD. Due to the

high comorbidity and phenomenological similarities, many researchers are in favor of broadening the definition of obsessive compulsive spectrum disorders to include eating disorders such as anorexia nervosa and bulimia.

One distinction between the two disorders is that the characteristics of OCD are ego dystonic while those of anorexia nervosa are more ego syntonic. That is, OCD sufferers realize that their actions are at odds with their best interests, while the anorexics view their actions as acceptable. This difference must be considered in treatment planning. Due to the complication of distorted body images of anorexics, the collaboration between various treatment professionals specializing in OCD and eating disorders is essential for an effective treatment outcome.

Psychoeducation on appropriate diet, nutrition, exercise, and weight management is extremely important at the beginning and throughout treatment. In addition, cognitive-behavioral therapy (CBT) that addresses abnormal thoughts and behaviors, and that aims at developing coping resources for stress management is the most effective treatment for OCD and eating disorders.

Cognitive restructuring helps to reduce negative self-image, feelings of helplessness, and negative thinking patterns. Psychotropics involving antidepressants and selective serotonin reuptake inhibitors (SSRIs) may also be considered to improve symptoms of anorexia and OCD. Group therapy provides support and corrects inaccurate self-judgments and misperceived information. Furthermore, family therapy provides support and psychoeducation to family members, and addresses underlying family dynamics, which is especially necessary if the patient is a young adolescent living with family members.

Exposure and response prevention (ERP) reduces the anxiety of becoming overweight by exposing the patient to images of perceived fat. For instance, patients are instructed to wear tightly fitted clothes, listen to grossly exaggerated loop tapes about being overweight, write self-scripts of becoming obese, and experience feelings of fullness after meals. Patients are prevented from excessive exercise and compulsive weight checking. As with BDD, crooked mirrors are used to expose and externalize patients' distorted internal body images.

This year, two patients with severe OCD and anorexia nervosa have come through the Westwood Institute for Anxiety Disorders, Inc. in Los Angeles. One has completed treatment with significant improvements while the other is currently

in treatment. Both patients were drastically underweight with life-threatening conditions in which they had to be fed through feeding tubes.

The first patient was a 16-year-old male with magical thinking, fear of gaining weight, fear of making mistakes, and fear of contamination. His problems were triggered when, after breaking his jaw in a skateboard accident, his jaw had to be held up with bandages for a year. This limited his ability to move his mouth and chew; and during this healing process, he was only able to eat through tubes. Since he lost weight during the year, he continued to limit his food intake even after his jaw had healed, so that he would not become fat again.

A little over a year later, he experienced a second skateboarding accident in which he broke his leg. As a result of the two traumas that he endured within a short duration of time, he began to believe that "bad luck" was following him. Within a few months, his magical thinking increased and his obsessive concern with food and weight worsened. He began developing compulsive behaviors such as repeating, correcting, checking, washing, and perfecting. For instance, he would walk around the dinner table and chair again and again until he felt "just right," or he would have to touch door knobs before engaging in any activity. He also developed food-related rituals in which he would divide his food perfectly into smaller portions.

During the initial evaluation, his functioning had deteriorated to the point that it was life-threatening. He had to be withdrawn from school due to his diminished capacity to concentrate. Rituals became more severe and consumed most of the day. He had lost over 40 lbs. within a few months, and his blood pressure continued dropping. He was experiencing black-outs, and was unable to leave his house. His magical thinking was indicative of overvalued ideation and was tightly intertwined with the anorexia. His Yale-Brown Obsessive-Compulsive Scale (YBOCS) score of 36 and Hamilton Rating Scale for Depression (HAM-D) score of 35 indicated severe OCD and depression.

Due to the severity and comorbidity of his OCD and anorexia, treatment involved 4 weeks of inpatient care at the eating disorder unit at UCLA's Neuropsychiatric Institute and Hospital. Upon discharge, he participated in the outpatient day treatment program for another 5 weeks. An intensive CBT regimen to target his obsessive-compulsive symptoms was started simultaneously. The treatment utilized progressive exposures to feared stimuli coupled with

complete response prevention. Thus, he was discouraged from engaging in any rituals in order to maximize the effectiveness of exposures. In addition to each daily session, he was given two to three hours of daily assignments that closely paralleled the skills acquired from each day's session.

Over the course of therapy, he struggled with the treatment process. Initially, he had significant difficulties following directions in accordance with this treatment plan, and he put forth only minimal effort in daily assignments. However, toward the end of treatment, his motivation level increased substantially as his obsessional fears declined. At termination of treatment, his YBOCS and HAM-D scores were 7 and 6, respectively.

The second patient is a 14-year-old male with fear of gaining weight and fear of making mistakes. His condition was influenced by his twin brother's obsession with "healthy food" and was precipitated by a general instruction from his track coach. Within a short period of time, his symptoms became more severe. He began developing food rituals in which he would use his hands to break the food into very small pieces before putting it into this mouth. This ritualistic process increased his meal times considerably, which interfered with other academic and social activities. He also began developing repetitive compulsions, such as flipping light switches, opening/closing doors, pacing up and down the stairs, and touching his face in a particular manner. These rituals had to be performed strictly to avoid "feeling uncomfortable."

At the initiation of treatment, he was losing weight at the rate of 8 lbs/week due to his food refusal, and was down to a total weight of 87 lbs. He was deficient in electrolytes, his cardiac rate had dropped to the 40's, and he experienced bladder and bowel retention. He reported that he was having difficulty eating due to the performance of excessive rituals during meal times. His YBOCS score of 39 indicated severe obsessive-compulsive symptoms. Due to his life threatening condition, he was admitted to the eating disorder unit at UCLA's Neuropsychiatric Institute and Hospital. At the time that this article was being written, it had been 4 weeks since his admission, and he was continuing to struggle with his condition. At the time a feeding tube was necessary to provide him with nutrition.

On an interesting note, his twin brother has also been admitted to the eating disorder program at UCLA. The attending clinicians suspect that he also has some slight obsessive-compulsive symptoms. Specifically, he appears to have obsessive concerns involving "healthy food" that stemmed from fears of gaining weight and food contamination. His related rituals include reassurance seeking and checking behaviors.

I Was Just Thinking: Fear, Advertising and OCD

By Jared Kant

Research has shown that events that occur in our lives that produce anxiety will exacerbate obsessive compulsive brain activity. An anxiety disorder feeds off distressing things, and OCD is the prime example of this. Lately, with what's been on television and on the radio and even in the papers, I've come to the conclusion that the world is so tremendously chaotic, I couldn't possibly make it any worse, no matter how many times I forget to wash my hands.

We learned very quickly after the terrorist attacks in September of 2001 that an incident that occurs anywhere in the globe can leave hundreds, even thousands of OCD sufferers wondering if they didn't cause this catastrophe and what they have to do as penance. When Hurricane Katrina devastated nearly 400,000 homes in New Orleans alone, another wave of OCDers found themselves wondering the same thing. Did I do this? Was I not praying enough? Am I being punished?

However, this is only the tip of the iceberg, pardon the cliche. If you really look into it, we live in a culture that thrives off of the idea that fear is the best selling concept next to sexuality. With fear, of course, OCD is never too far behind to shake things up even more.

The other night, my girlfriend's mom walked over to her son and me, carrying a box of wet napkins soaked in an insect repellent. The box advertised in big letters, white on blue, that "this product repels mosquitoes that may carry WEST NILE VIRUS." Suddenly, looking at this obnoxious ploy to exploit people's natural instinct to survive and general ignorance about the viability of these claims, I found myself convinced that the strange markings I noticed earlier that morning on my chest must have come from one of these insect-borne diseases. I panicked and lifted my shirt. "What is this?" I asked them.

No one really knew. I spent a long time today researching it, and I think it's a spider bite, or rather a series of them. Regardless, all that anxiety was over nothing. So it should have come as no surprise to me when an intrusive thought kicked in at the same time as I was examining a bottle of body wash and a strange looking blemish. Suddenly, I became concerned that I was in an advertisement for a name-brand body wash. It's almost twenty-four hours later and not having slept, I'm still concerned that the world is trying to use me as a billboard.

So what can we actually draw from this? It's easy to put down facts and figures, but can we

extrapolate any useful information from this episode? I think the first thing we need to realize is that there is simply too much media around us. Media is a great thing, understand that, after all, you are reading an article in a great publication, but not all media outlets are positive. As well, there are people working around the clock to exploit your fears and anxiety to get you to compulsively hoard coupons and stockpile batteries and bottled water, buy name brand bug spray and over-wash yourself.

We can infer then that the best treatment for a media overload as it relates to OCD is to reduce the amount of stimulus in your immediate vicinity. If nothing else, consider putting blank stickers over all the product features on boxes that use this "culture of fear."

Exercise your ability to remove yourself from the situation when a tragic event happens. You cannot affect the world's oceans, even if you try. So remember that you did not cause the Tsunami, the hurricane, or even the recent snow in South Africa. You're living in a complicated world with a complicated disorder. Just be careful how complicated you let it become.

2007 RESEARCH AWARDS

(continued from page 1)

In 2006, the Foundation gave out seven Research Awards amounting to \$331,081.

"The deadline for the submission of proposals is January 15, 2007," said Jeannette Cole, deputy director of the OCF. All submissions for the 2007 Research Awards, advised Ms. Cole, must be submitted by e-mail.

For application guidelines or more information, contact Ms. Cole at cole@ocfoundation.org, or call 203-401-2069.

Please
Contribute
to the
OCF Research
Fund

Research Digest

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

Treatment of obsessive-compulsive disorder by U.S. psychiatrists

Journal of Clinical Psychiatry, 67:946-951, 2006, C. Blanco, M. Olfson, D.J. Stein et al.

Typical treatment of OCD by U.S. psychiatrists was studied by analyzing data from 1997 and 1999 surveys of nationally representative samples of psychiatrists. The goal was to see how routine practice conformed to evidence-based standards. Data were available on the treatment of 123 patients with OCD. Sixty-five percent of patients received a serotonin reuptake inhibitor (SRI), but only 39% of these patients received an SRI at a dose thought to be most effective for OCD. Although the majority of patients (77%) received psychotherapy, only very few (7.5%) received cognitive-behavioral therapy (CBT), which is the only psychotherapy with strong research support for the treatment of OCD. Prescription of benzodiazepines or antipsychotics was common, often in the absence of an SRI. Interestingly, patients receiving CBT had on average the highest scores on the Global Assessment of Functioning Scale. Authors concluded that despite important advances in the treatments for OCD, psychiatric care of OCD is in need of quality improvement.

Female hormones affect symptom severity in obsessive-compulsive disorder

International Clinical Psychopharmacology, 21:171-175, 2006, N.C.C. Vulink, D. Denys, L. Bus et al.

This study examined the relationship between severity of OCD symptoms and female reproductive events – premenstrual period, menopause, and pregnancy. Women with OCD (101 adults) completed a self-report questionnaire. Approximately half of the women (49) reported a worsening of OCD symptoms during the premenstrual period. Nine women reported a worsening of OCD symptoms during menopause (47% of menopausal women), 17 during pregnancy (33% of women who were pregnant) and 25 in the postpartum period (48% of women who delivered babies). Interestingly, 11 women (21% of pregnancies) reported a moderate improvement in OCD symptoms during pregnancy. There was no correlation between discontinuing medications during pregnancy and worsening of symptoms, as only 3 of the 17 women discontinued SSRI treatment before

pregnancy. There was no significant difference between patients with and without premenstrual worsening of OCD symptoms based on age, regularity of menses, OCD subtypes and use of oral contraceptives. Researchers speculated on psychological (stress) and neurological (effects on dopamine) causes for the worsening of OCD symptoms.

Impact of obsessive-compulsive disorder on quality of life

Comprehensive Psychiatry, 47:270-275, 2006, J.L. Eisen, M.A. Mancebo, A. Pinto et al.

Although OCD is the tenth leading cause of disability of all medical conditions in the industrialized world, comparatively little is known about psychosocial functioning and quality of life, particularly with regard to their relationship with OCD symptom severity. Quality of life and psychosocial functioning of 197 adults were assessed, using several self-report and clinician-rated measures. All aspects of quality of life were significantly impaired. This impairment was positively correlated with OCD severity and comorbid depression severity. In this study, 67 (34%) of individuals were unable to work because of OCD; 9 (5%) were unable to perform any household tasks; and 28 (14%) were receiving disability because of OCD.

Clarifying the convergence between obsessive compulsive personality disorder criteria and obsessive compulsive disorder

Journal of Personality Disorders, 20:294-305, 2006, J.L. Eisen, M.E. Coles, M.T. Shea et al.

Obsessive compulsive personality disorder (OCPD) is characterized by excessive preoccupation with orderliness and perfectionism. Diagnostic criteria for OCPD includes the presence of four or more of the following traits: excessive preoccupation with details, perfectionism that interferes with completing tasks, excessive devotion to work, inflexibility with morality, hoarding, reluctance to delegate tasks, miserly spending style toward both self and others, or being rigid and stubborn. OCD and OCPD are separate disorders that share some of the same symptoms. This study examines the relationship between OCPD and

OCD. Three of the eight OCPD criteria – hoarding, perfectionism, and preoccupation with details – were significantly more frequent in subjects with OCD (n=89) than in subjects without OCD (n=540). In addition, other anxiety disorders and depressive disorder showed few associations with specific OCPD criteria. Of 629 participants in this personality disorders study, 262 (42%) were diagnosed with OCPD and 89 (14%) were diagnosed with OCD. Of those individuals with OCPD, 20% had OCD. OCD was significantly more frequent in subjects with OCPD compared to subjects with other personality disorders. Although OCPD and OCD are classified as separate disorders, there is an association between the two disorders. These findings support a unique relationship between OCPD symptoms and OCD, suggesting a possible subtype of OCD characterized by perfectionism, excessive attention to detail, or hoarding.

Response versus remission in obsessive-compulsive disorder

Journal of Clinical Psychiatry, 67:269-276, 2006, H.B. Simpson, J.D. Huppert, E. Petkova et al.

This is a re-analysis of data from a controlled trial comparing the effects of 12 weeks of behavior therapy (using exposure and ritual prevention), medication therapy (clomipramine [Anafranil]), their combination (behavior therapy plus medication), or placebo in 122 patients with OCD. This controlled trial was presented in the Late Fall 2005 Research Digest. Here the data are analyzed to consider remission, not just a reduction in symptoms. Response was defined as a decrease in symptoms; remission was defined as minimal symptoms after treatment measured by a Yale-Brown Obsessive Compulsive Scale (YBOCS) score of 12 or less. In considering remission, significantly more patients treated with behavior therapy alone or behavior therapy with medication achieved remission than either medication alone or placebo. Researchers conclude that many OCD patients who receive evidence-based treatments will not achieve remission and patients receiving medication only are unlikely to reach remission. They suggest that OCD patients should have access to behavior therapy if the goal of treatment is not just a reduction in symptoms but an excellent outcome.

Probability of obsessive and compulsive symptoms in Huntington's disease

Biological Psychiatry, Epub ahead of print, 2006, L.J. Beglinger, D.R. Langbehn, K. Duff et al.

Obsessions and compulsions have been reported in patients with Huntington's disease (HD). Presumably, this co-occurrence is because the pathophysiology of both disorders, OCD and HD, involves abnormal metabolism in the same areas of the brain. This study examines the probability of obsessive and compulsive (OC) symptoms across stages of HD. Using the Unified Huntington's Disease Rating Scale, OC symptoms were assessed in a large sample (3,964) of individuals at risk for HD. The probability of comorbid OC symptoms increased with greater severity of HD. Individuals with no motor abnormalities ("at risk") had a 7% probability of obsessions and a 3.5% probability of compulsions. Patients with advanced HD with significant functional disability had a higher probability for obsessions (24%) and compulsions (12%). The probability of OC symptoms was more than 3 times greater for individuals with severe HD than for the at-risk group with no apparent motor abnormalities. Obsessions were more common than compulsions; this difference increased as subjects aged. Overall, the OC symptoms were slightly less common than other psychiatric symptoms co-occurring in patients with HD – depression, suicidality, aggression, and irritability. Interestingly, OC symptoms were the only psychiatric symptoms that increased with disease progression; anxiety and depressive symptoms were more stable or declined with increasing disease.

Antidepressant discontinuation syndrome: consensus panel recommendations for clinical management and additional research

Journal of Clinical Psychiatry, 67(Suppl 4):27-30, 2006, A.F. Schatzberg, P. Blier, P.L. Delgado et al.

In 1997, a panel of experts proposed guidelines for the management of SRI discontinuation syndrome characterized by symptoms of varying severity including anxiety, insomnia, dizziness, and nausea sometimes described as "flu-like." This current panel convened in April 2004. The panel reviewed clinical studies on SRI discontinuation syndrome, discussed areas for future research, suggested establishment of a research network to collect data and updated the 1997 management guidelines. For management, gradual tapering of drug doses and substitution with longer-acting drugs, such as fluoxetine

(Prozac), were still the best strategies for minimizing and/or preventing SRI discontinuation syndrome. In addition, patients should be monitored, from the time of discontinuation through about 2 weeks afterward. Patient education is very important and clinicians need to reassure their patients that this syndrome is easily manageable. Clinicians need to educate patients about the possibility and nature of discontinuation symptoms, the importance of taking medication consistently, and the general need to taper medication at the end of a course of treatment of 3 to 4 weeks or longer to minimize the occurrence of such symptoms. Additionally, clinicians should emphasize that this SRI discontinuation syndrome does not indicate addiction or drug dependence.

Good News From the Federal Courts

(continued from page 1)

Of course, this is great news for the particular insured in this case and equally great news for all OCD sufferers to have an appeals court recognize that the nature of OCD is physical or organic as opposed to being a mere neurosis or eccentricity. Now lawyers like me who bring Family and Medical Leave Act (FMLA) claims or Americans with Disabilities Act (ADA) claims can point to this opinion as controlling precedent in the 11th Circuit that OCD is a physical condition that just so happens to manifest itself through "mental" symptoms.

The bad news is that I bet right now all the insurers in 11th Circuit are busily scribbling changes to their future insurance policies to exclude all "mental illnesses" regardless of whether they are caused by objective physical criteria or not. In the legal business, definitions are everything.

Overall, a big step in the right direction!!! To read the whole opinion, go to <http://caselaw.lp.findlaw.com/data2/circs/11th/0511663p.pdf>.

Attorney Hollified can be reached at trh@trhlaw.com

Free Medication

Can't afford the prescription drugs you need to control your OCD? The Partnership for Prescription Assistance (PPA) may be able to help you. According to its web site, PPA is the result of a private sector effort whose purpose is to help patients gain access to the prescription medicines they require for little or no cost. The PPA was started to link patients to a centralized clearing house for the patients' assistance program.

PPA was initiated in 2005 by Pharmaceutical Research and Manufacturers of America (PhRMA). PPA brings together America's pharmaceutical companies and national and local organizations. PPA's mission, according to its web site, "is to increase awareness of patient assistance programs and to boost the enrollment of individuals who are eligible for free or low cost medication."

PPA has the ability to link people who need but cannot afford certain medications to the more than 475 public and private patient assistance programs which provide free or nearly free drugs to people with limited incomes.

To find out if you qualify for any of these assistance programs, you can call a toll-free number (1-888-4PPA-NOW) or go to the PPA's web site at www.pparx.org. Each of the 475 assistance programs has its own eligibility requirements. So if you do not have prescription coverage and are having trouble affording your medications, it's time for you to connect with PPA and find out if you are eligible for drugs for free or at minimal cost.

An Interview With Dr. Jaime Feusner UCLA Intensive Treatment Program

Dr. Jaime Feusner has recently been appointed medical director of the UCLA Intensive Treatment Program. In the interview that follows he talks about the UCLA program and describes the techniques they use at UCLA to treat OCD.

NEWSLETTER: You are now in charge of the Intensive Treatment Program at UCLA. Can you tell me how your program is set up?

DR. FEUSNER: The UCLA OCD Program is an intensive treatment program for people suffering with moderate to severe OCD.

NEWSLETTER: What kind of treatments do you employ in your Intensive Treatment Program?

DR. FEUSNER: Participation in the Intensive Treatment Program begins with a comprehensive psychiatric assessment and medication evaluation. The program provides up to three hours daily of behavior therapy in the form of exposure and response prevention (ERP). Each patient is assigned his/her own behavior therapist with whom s/he will work one-on-one for at least one hour each day. We use primarily ERP to target OCD symptoms, yet also provide extensive psycho-education, cognitive restructuring, family education, general life skills, and medication management.

NEWSLETTER: Is your program a residential one or a partial hospitalization program?

DR. FEUSNER: This is a partial hospitalization program.

NEWSLETTER: How many hours a day is your program?

DR. FEUSNER: It is 4 hours per day.

NEWSLETTER: Is it a five day a week program?

DR. FEUSNER: Yes.

NEWSLETTER: What if someone wants to go to your program, but doesn't live within commuting distance? Where would s/he stay? What kind of arrangements can be made for the out-of-town patient?

DR. FEUSNER: We often have individuals come from out-of-town. We provide

a list of local hotels and motels, several of which are within walking distance of the program.

NEWSLETTER: Do you use both medication and cognitive-behavioral therapy?



The UCLA Intensive Program Staff

DR. FEUSNER: Yes. Most individuals who come to the program are already taking one or more medications for OCD. In those cases, our psychiatrists will evaluate the medication regimen and may make recommendations for minor adjustments to help with side effect issues, etc. As the primary focus of treatment in the program is exposure and response prevention therapy, the goal with the medication is usually to facilitate this therapy. For example, we may use medications to help with depressive symptoms or other comorbid problems. At times, when the OCD is very severe and the individual cannot engage adequately in the ERP, we may recommend additional OCD medications to help facilitate participation in the therapy.

NEWSLETTER: How many treatment providers do you have in your program? What is each one's background, training and experience?

DR. FEUSNER: We currently have three cognitive behavioral therapists and two psychiatrists in the program. Every patient is assigned an individual therapist and a psychiatrist. Each therapist comes from a slightly different discipline (social worker, psychologist, nurse, marriage and family therapist) which provides for a broad and comprehensive treatment approach. All the

therapists are well-qualified and experienced in the area of cognitive-behavior therapy for the treatment of OCD. I am the Medical Director of the OCD Intensive Treatment Program and I provide medication management for the patients. There is also a UCLA resident psychiatrist who works under my supervision.

NEWSLETTER: How long does your Intensive Treatment Program usually last? What if a participant needs more behavior therapy work? Do you keep them over the initial time period set up for treatment?

DR. FEUSNER: The program is 6 weeks long (that is, 30 treatment days). We do have some flexibility; on occasion we will extend it to 8 weeks if needed. Because OCD is a chronic condition, every individual will need additional behavioral therapy after the program. Our goal in the program is to provide a significant reduction in symptoms with ERP and medication management to help improve functionality. Treatment always needs to be continued afterwards on an outpatient basis, and we work hard to ensure that patients have adequate outpatient follow-up when they leave. Relapse prevention is a big focus of the program.

NEWSLETTER: Do patients in the Intensive Treatment Program meet and work with each other? Are there group therapy sessions? How many people are typically in the Intensive Treatment Program?

DR. FEUSNER: Yes, the patients get to meet each other and interact quite a bit. We have a different group session every day, including Cognitive, Relapse Prevention, Goal Setting, Coping, and Didactic groups. Many patients tell us that the support they receive and the camaraderie that happens in the program is very motivating and therapeutic. There are up to 6 patients at a time in the program. I think this creates an intimate and individualized feel, while giving the patients opportunities to learn from others and feel supported.

NEWSLETTER: What is the difference between your Intensive Treatment

About The

Program and regular weekly office visits with a behavior therapist?

DR. FEUSNER: In the program patients receive supervised exposure and response prevention exercises on a daily basis, for several hours. We also encourage them to continue the response prevention and do exposures at home, in the evenings and on weekends. This provides a much more intense treatment setting than outpatient office visits with a therapist. In the outpatient setting, an individual may do an in-session exposure once or twice a week and needs to stay on top of doing his/her ERP "homework" on his/her own.

NEWSLETTER: Who decides what medication a participant in the Intensive Treatment Plan will take?

DR. FEUSNER: Every participant meets with a psychiatrist for an initial evaluation, and then at regular intervals thereafter while in the program. Most participants are already taking medications when they arrive. The treating psychiatrist will review these medications, the medication history, and other additional psychiatric and medical conditions that a program participant may have, and then makes a decision with the patient about the medication plan. The treating psychiatrist will also consult with the participant's outpatient psychiatrist to gain additional treatment information and coordinate follow-up care.

NEWSLETTER: How do you introduce cognitive behavioral therapy and exposure and response prevention to a participant? Do you start slowly and gradually build up?

DR. FEUSNER: We start with a discussion about OCD and about how the cycle of obsessive thoughts, feelings and behaviors maintains itself. When individuals are clear about the rationale for treatment, we help develop a hierarchy of obsessional fears to address with behavioral therapy. Using this hierarchy, we will have the patient start by addressing fears that are lower on the hierarchy (less intense) and gradually progress upwards.

NEWSLETTER: You're affiliated with UCLA. Can you admit someone to one

of UCLA's inpatient programs if a participant really needs to be hospitalized?

DR. FEUSNER: Yes, we are able to admit someone to the inpatient psychiatric unit at UCLA if a situation arises that warrants doing so, such as if someone is suicidal. After the person has stabilized, s/he may be able to return to our program. However, we do not have an inpatient or residential OCD treatment program at UCLA.

NEWSLETTER: What practices do you employ to prevent relapse?

DR. FEUSNER: We help individuals start to think about relapse prevention from the first day of the program. We begin planning and arranging for the appropriate follow-up outpatient cognitive-behavioral therapy and medication management from very early on. We also have a weekly Relapse Prevention group, to stress the importance of follow-through with cognitive-behavioral therapy after the program and medication adherence. We also assess and discuss with patients throughout the program how they are functioning in all domains of their life, and how they may need to expand their activities (work, volunteering, social activities, hobbies, etc.) to fill the "void" that often results when someone who has had severe OCD for years that has occupied much of his/her life. When it is time for discharge, we communicate with his/her follow-up therapist and psychiatrist to facilitate the transition and ongoing treatment.

NEWSLETTER: If someone relapses, can s/he get back into the program?

DR. FEUSNER: Absolutely. Relapse can occur, and sometimes individuals with severe OCD may need to go through the program more than once to ultimately get to a place where their symptoms are more manageable and they can maintain their gains in an outpatient setting.

NEWSLETTER: Do you offer support groups for people who are or have participated in your Intensive Treatment Program?

DR. FEUSNER: Yes. I run a weekly free OCD Education and Support Group. We encourage individuals who have finished the program to participate in this group, which allows them to continue to gain from the support and motivation that a group can provide, and serve as a weekly reminder about the importance of keeping up with

response prevention techniques and their exposure exercises they may be doing with their outpatient therapists. Many patients find that this helps with relapse prevention.

NEWSLETTER: Do you treat OCD Spectrum Disorders at the program? Which ones?

DR. FEUSNER: Yes, we treat Body Dysmorphic Disorder, Hypochondriasis, and Trichotillomania, to name a few.

NEWSLETTER: Can you tell our readers about the work you are doing with hoarding? Is it separate from the Intensive Treatment Program?

DR. FEUSNER: We have many individuals with compulsive hoarding come through our program. Their actual day-to-day treatment is somewhat different than the treatment of other subtypes of OCD in that they practice sorting/discarding, decision-making, and organizational skills. However, they participate in the same groups and are otherwise part of the same general program.

NEWSLETTER: Which types of patients are suited for your program?

DR. FEUSNER: Our program is most appropriate for patients with moderate to severe OCD. Most of the individuals we treat find that their OCD prevents or significantly interferes with their ability to function at work and school and, often, interpersonally.

NEWSLETTER: Is treatment given in your Intensive Treatment Program covered by private insurance, Medicare or Medicaid?

DR. FEUSNER: Most insurance plans, including Medicare, cover treatment in the program. Always check with your insurance company about the specific coverage you have.

NEWSLETTER: Do you have scholarships or subsidized payment arrangements?

DR. FEUSNER: At this time, unfortunately we do not.

NEWSLETTER: With whom should anyone who is interested in your program get in touch? How can they do that?

DR. FEUSNER: If you are interested in the program, please call Karron Maidment at (310) 794-7305 for more information. To be admitted to the OCD Intensive Treatment Program, call 1-800-825-9989, option 2, to set up a screening evaluation with Dr. Tanya Vapnik.

A Consumer's Thoughts on Intensive Behavior Therapy Treatment

Lynn* is a 56 year-old married teacher who recently completed the UCLA OCD Intensive Treatment Program. In the following interview the director of the program, Dr. Jamie Feusner, interviews Lynn about her treatment to provide a sense for others of what the program is like.

DR FEUSNER: Thanks for agreeing to talk to me about your experience in the UCLA OCD Intensive Treatment Program. First of all, tell me a little about yourself and what you've experienced in terms of OCD.

LYNN: I started having OCD symptoms at 18 in high school. Back then I had some checking compulsions. This continued into college where I almost flunked out because of rereading. Fortunately, I was able to do a program with less reading and intensive work, so was able to graduate. It was still very difficult because of my OCD. My contamination fears developed in college, and I started washing my hands excessively. At the time no one knew it was OCD. I was in psychotherapy, but it was not behavioral therapy. I found out I had OCD in 1985 when I saw the episode on "60 Minutes" and realized it applied to me. I started taking meds and continued doing some psychotherapy. More recently, my OCD got more severe and I got very depressed. I was almost ready to quit my job. My main issue now has to do with contamination, and I'm afraid of feces and urine. Before treatment, I would avoid almost anything that remotely would have come in contact with feces or urine, or had touched something that might have. I was also washing laundry excessively and would throw away shoes regularly.

DR FEUSNER: What treatments have you had for your OCD?

LYNN: I had medication treatments starting in 1985. I've had psychotherapy but not any behavioral therapy before this program.

DR FEUSNER: How did you first find out about the UCLA OCD Intensive Treatment Program?

LYNN: A friend first told me about the Anxiety Disorders Clinic at UCLA, and I found out about the program while being screened for that clinic. I also met a woman on the internet through Yahoo groups, who told me about the program. And you [Dr. Feusner] recommended it to

me when you screened me for your OCD group.

DR FEUSNER: What other treatment options were you considering at the time?

LYNN: Just continuing the psychotherapy and seeing the psychiatrist I was seeing at the time.

DR FEUSNER: Were you considering any other day treatment or residential programs?

LYNN: I was considering inpatient psychiatric hospitalization at that point because of how bad my depression and OCD were. My world had become very small and I was unable to do a lot of the things I was able to before. Many of my friends noticed that I was in bad shape.

DR FEUSNER: How did you decide on this one?

LYNN: I liked the way it sounded, and I had never tried behavioral therapy before so I wanted to try it. Also, it worked well with my schedule because I had the time off from work over the summer.

DR FEUSNER: Was it covered by your health insurance?

LYNN: Yes. My insurance paid everything but a \$100 co-pay.

DR FEUSNER: Can you remember how you felt about coming into the program?

LYNN: I was frightened, scared. Some people in my OCD group said that I would have to touch things that I didn't want to.

DR FEUSNER: What did you imagine it would be like?

LYNN: I understood that a therapist would work with me one-on-one. Otherwise I didn't have a clue as to what I would do. I heard I would have to do exposures, but I really didn't know what those were.

DR FEUSNER: Was it any different than your expectations?

LYNN: Yes. I didn't think I was going to be able to do what I had to, but I was able to do the work because of how much support they gave me. I was able to get rid of many of the compulsions and some of the obsessions. My symptoms improved 66 2/3%.

DR FEUSNER: What did the actual treatment involve?

LYNN: I met with a therapist in the morning for an hour, and then I worked on exposures. Then there were group therapy meetings. In the last hour I worked on the exposures on my own.

DR FEUSNER: How difficult was it?

LYNN: The first week I was really exhausted from it, and had to nap in the afternoon. The second week when they started the exposures was probably the hardest week. By the fifth and sixth week it was getting easier. I think really anybody with OCD could handle it if they are really motivated.

DR FEUSNER: How was it for you interacting with the other patients?

LYNN: It was very good. I am still in touch with some of the other patients. They were very supportive, like the staff was. Even though the others had different obsessions, they were still understanding of mine.

DR FEUSNER: Has the treatment been helpful for you?

LYNN: Yes, by 66 2/3%. My husband is surprised that I can now take out the garbage. I am not afraid like I used to be and my world has seemed to open up a little more. When I did my first exposure, I nearly backed through the wall!

DR FEUSNER: How did you feel when you finished the program?

LYNN: Very good. I felt relieved that I was able to do the exposures. I felt accomplished with having gone as far as I did with the program.

DR FEUSNER: How are you doing now?

LYNN: It's been 3-4 weeks since I've been out of the program. I miss the daily support of the program. I continue to do much better in terms of my OCD symptoms. School has started again so I'm back at work now and I'm handling it.

DR FEUSNER: What do you think will be important for you to maintain your gains?

LYNN: I need to have continued therapy with an OCD specialist and treatment from a psychiatrist. Oh yeah, and I need to continue to do my exposures.

* Her name has been changed to protect her privacy.

Intensive Treatment

DR FEUSNER: What type of follow-up treatment are you involved in?

LYNN: I am going to the UCLA Anxiety Disorders Clinic for medication management, and I'm doing psychotherapy once a week for continued support and cognitive-behavioral therapy. I am also going to your support group every week.

DR FEUSNER: What did you like the most about the program, and what did you like the least?

LYNN: I liked the continued support from the staff and the way they encouraged me to face my difficulties. I didn't like the exposures, but I did them!

DR FEUSNER: What are the three most important things you learned from the program?

LYNN: Consistency, to face your fears instead of running away from them, and how to be more organized and prioritize things in my life.

DR FEUSNER: So you worked on some issues outside of your main contamination fears.

LYNN: Yes.

DR FEUSNER: Do you think the program helped your family's understanding of your OCD, and if so, how?

LYNN: Yes. My therapist had my husband come in to the program. Now he understands how debilitating and difficult it was for me. He also now sees that I've improved, and I'm now capable of doing things like taking out the garbage and not avoiding walking certain places. My stepdaughter also understands these things better now.

DR FEUSNER: What is your advice to someone who is considering a treatment program for OCD?

LYNN: I definitely think the program at UCLA is good. The things you need to look for in a program are trained and qualified therapists (not just ones who say they are), who have proven track records. The medication management is also really important. It's important to get the support of your family. You have to really be motivated to want to improve; so part of it is yourself!

DR FEUSNER: Thank you for your insights, Lynn.

Message From the President

Dear Friends,

My husband and I have attended so many weddings this year that my cousin jokingly describes us as "the wedding crashers." Each event has reflected the personality of the bride and groom and last weekend's celebration was no exception. However, what made this one unique was the hope that it brought to all those who suffer with Obsessive Compulsive Disorder.



Twelve years ago when my son was diagnosed with OCD, I decided to attend the Annual OCF Conference in Boston. Things at home had been really difficult so my husband and I took turns attending the workshops. For me, it was hard to go alone; but at that particular time in our lives, I did it a lot.

I learned more about OCD at the conference; but more importantly, I made a life long friend who shared my situation. Her son had just been diagnosed with OCD and she was at a loss as to what to do as well. Over a salad and a bottle of water, we cried and shared our personal stories. We were terrified that our dreams for our sons were now unattainable.

Who would have imagined that twelve years later, her son would walk down the aisle with a beautiful, young woman whose parents had welcomed him into their family? In his toast at the wedding reception, the father said his prayers had been answered.

It is events like these that keep us moving forward. I came home that night energized for our cause: to continue to educate the public on Obsessive Compulsive Disorder, to raise more money for research, and to find effective treatments for all suffering from OCD. It made me feel even more committed to an initiative that is special to our family and

shared by the Foundation.

Last year my family started the Behavioral Therapy Institute Fund (BTIF). The fund offers scholarships for treatment providers in underserved areas of the country who are not trained in Cognitive-Behavioral Therapy (CBT) using exposure and response prevention techniques. The scholarships will cover the registration fee for the BTI. After attending the BTI, recipients must be willing to use CBT (especially ERP) in treating those with Obsessive Compulsive Disorder. Recipients are also encouraged to attend at least one OCF Annual Conference. These scholarships will be available for BTIs in 2007.

If you or anyone you know are interested in receiving a BTI scholarship, please contact Jeannette Cole, Deputy Director (cole@ocffoundation.org) for more information about the next BTI, applicant eligibility and the application process.

At this time of year, we can be thankful that we have come a long way since the Foundation was started twenty years ago. Let hope light the way to a brighter future for all of us.

Best Regards,

Joy Kant
President of the OCF Board of Directors

CONGRATULATIONS TO THE WINNERS OF THE OCF ART CONTEST

KAREN GROVE – FIRST PRIZE

MIMI DOAN – SECOND PRIZE

CLAY GRIFFIN – THIRD PRIZE

PATIENT – THERAPIST TEAM KO'S OCD

(continued from page 1)

ine doing, harming a child, and from that moment my true hell on earth began. I began to worry that I was raping or molesting children. I could walk into an empty bathroom and worry on the way out that I raped a child in there. While walking on campus, I worried that maybe I raped someone on the way to class. I would walk anywhere or go anywhere and worry about who I maybe killed or raped. I couldn't escape the worries even in my own home. I worried that I had kidnapped a child and brought him to my house. In the shower I worried I might have raped a child. I would have to look at the bottom of the tub to see how many feet there were to assure myself I was alone.

All day long I had images and thoughts of raping children. I would see it all in my head and it drove me insane. There was no escape. My mind and fears grew more creative and sicker as time progressed. One evening I pictured a blanket of dead babies on top of me in bed. I was so afraid and was getting more and more depressed. I didn't go out with my friends, and preferred to stay at home crying myself to sleep.

I began to intensely monitor feelings in my genitals to ensure I was not aroused at the sight of a child. It was around this time that I began to feel as if I was compelled to act on the thoughts I was having. This terrified me more than anything else I had encountered, and was when I seriously considered killing myself.

I was spiraling into madness and my hopes of ever reclaiming my old life were fading rapidly. I had seen many different doctors, but all of them had little success in assisting me. Finally, I discovered something on the internet about the symptoms of OCD. The list of symptoms paralleled what I had experienced, and for the first time I was hopeful that someone could help me.

I saw a psychiatrist who started me on Prozac, and he also referred me to Dr. Bubrick, who specializes in OCD treatment. After a few months of treatment, I finally started making some progress. I am now much more active with my friends, and feel comfortable hanging out in public again. I started working part-time, and am doing many things

now that would have caused a great deal of anxiety and pain before. I've found the hope I thought I had lost. I have learned so much from my treatment, and I have many new weapons in my fight against OCD.

OCD no longer paralyzes me as it had in the past, and I hope with time and continued therapy that it becomes nothing more than an annoyance. I am not cured and I still have many difficult days ahead, however, I now know that OCD can be defeated. I am living proof that great progress can be made in the battle against OCD. I have improved a great deal; and although the battle will not be easy, I do intend to win.

Dr. Bubrick's Story

I admired Dan from the moment I met him. I could see he was struggling, but he had a fighting spirit and was motivated to get better. He told me in our first session that he was tired of going to doctors and therapists who didn't understand OCD, and really just wanted to see someone who could help him.

He talked about his obsessions, which were about purposely harming others while driving, and sexual obsessions about touching children, which were much more invasive and debilitating. As I provided Dan with some basic psycho-education about OCD, I could visibly see a calming within him.

We agreed that it was important that Dan start exposures first with his aggressive obsessions because it was easier for him to identify the thoughts as OCD, and he could learn the process and experience of exposure before tackling his sexual obsessions. We constructed a symptom hierarchy first for his aggressive obsessions, and listed all his compulsions and avoidances with respect to driving including: excessive rear-view mirror checking, retracing routes to insure no one was lying in the street, and his tendency to keep an exaggerated distance between his car and pedestrians or people getting into their cars. We then started the exposures with his lowest level items and worked our way up to higher level items.

Dan was great with driving exposures, and on our very first exposure, got more than he bargained for. He drove me around local streets and through a college campus, while trying to maintain a "normal" distance between his

car and pedestrians on the street. While driving through the university, we got a little lost, and he accidentally ended up driving down a pedestrian walkway. With me giggling beside him, he was able to drive down the narrow pathways, often coming very close to pedestrians, keep his composure and not resort to his compulsions. That experience set the stage for our exposures, and he was exceptional in his compliance with homework between sessions.

Once his aggressive obsessions were more under control, we agreed to address his sexual obsessions. This proved a little more difficult and he was more reluctant to engage in exposures. We did a fair amount of cognitive therapy first to diffuse the intensity of guilt he felt from having the thoughts. It was much harder for Dan to recognize the sexual obsessions as symptoms of OCD, and he berated himself for "allowing" such horrific thoughts into his mind.

One of the biggest obstacles we faced in the treatment of his sexual obsessions was his strong belief that he needed to perform a mental "moral checklist" of all the reasons it is wrong to touch children in sexual ways. He believed that if he didn't perform the moral checklist, he may somehow believe the OCD and follow through with actions, which he believed would have made him the worst scum in the universe. He also engaged in rituals and avoidances in efforts to prevent himself from coming into contact with children. He walked around with his hands in his pockets, increased the distance between himself and children in stores and walking in town, etc., so that he wouldn't touch anyone. We did exposures to these compulsions and avoidances, but he still held on tight to his moral checklist.

Eventually though, after several weeks of continued psycho-education and cognitive therapy, he came into a session and proudly reported he had allowed the thoughts to come in and resisted the urge to use the checklist. In that one moment, he took the risk that the thoughts were in fact OCD, and he treated them as such. Since then, his life has improved immensely. He has a much healthier attitude about his obsessions, recognizes when to do exposures, is much more active socially, and even voluntarily works with children. He now has the skills to fight his OCD, and I know he's going to win.

Living With Your Worst Nightmares: The Role of Mindfulness and Acceptance in Exposure and Response Prevention

By Jonathan Grayson, Ph.D. and Jodi Rosenfeld, Psy.D.
The Anxiety and Agoraphobia Treatment Center
Bala Cynwyd, PA

Acceptance and mindfulness are concepts that have been practiced in spiritual teachings for many thousands of years. More recently, psychologists have begun to apply acceptance and mindfulness techniques to the treatments of many different problems. Unfortunately, when new techniques are adopted, there is often a great deal of misinformation as to how to use them and what to expect from them. Currently, we are beginning to explore the usefulness of these techniques in the treatment of Obsessive Compulsive Disorder (OCD). In this article, we hope to answer three questions:

1. Does it make sense to incorporate acceptance and mindfulness techniques into the treatment of OCD?
2. What is acceptance and what is its role in the treatment of OCD?
3. What is mindfulness and what is its role in the treatment of OCD?

Exposure and Response Prevention (ERP) is still the core cognitive-behavioral treatment (CBT) of choice for OCD. The majority of sufferers will receive some benefit from ERP, even if it is poorly done. However, significant benefit as opposed to some benefit is our treatment goal. Because of this, those who work with OCD are always looking for ways to improve treatment. For example, there has been a great deal of work during the past few years focusing on adapting cognitive techniques from the CBT arsenal to the treatment of OCD. With the growing research and press coverage on acceptance and mindfulness, it makes sense for us to shift our attention to their usefulness in the treatment of OCD.

The answer to the first question is easy: yes. As Hannan and Tolin (2005) point out in a recent book chapter, ERP is already an acceptance-based technique. How is this so? At our Center, we see intolerance of uncertainty as the core problem for most manifestations of OCD. With this in mind, the goal of treatment is to learn to live with uncertainty, that is, to learn to live and cope in a world where your worst fears

might come true, i.e., that your house might burn down, that the world will always be dirty or that your loved ones might die. We define treatment readiness as being willing to learn how to accept living with uncertainty. We say learning, because if accepting uncertainty were a simple decision, then we would cure everyone in a single session. Acceptance of feared consequences is hard work, but this acceptance is critical if ERP is to commence. If the sufferer isn't willing to do this, then we won't begin the ERP part of treatment. To put it another way, how can someone get better if the goal isn't to get better?

Despite the fact that ERP is, by its nature, an acceptance-based procedure, further examination of acceptance and mindfulness provides us with an opportunity to improve and refine our use of these in ERP. Hopefully, this will result in better treatment and will, perhaps, help sufferers to choose the goals of treatment over suffering.

Having answered the first question and one-half of the second (what is the role of acceptance in the treatment of OCD), you may be wondering what acceptance is.

Acceptance and its opposite, denial, are terms you often hear mental health professionals use, but you rarely hear them defined. Let us start with denial. You may have been accused of this or have heard about someone having lost a loved one and being in denial over the death. Have you ever considered how this is possible? A mourner accused of this might likely challenge us and reply that they aren't in denial, that they know that their loved one has died and isn't coming back. If they didn't know this, we would be talking about psychosis or a break with reality rather than denial. Denial occurs whenever the sufferer is comparing fantasy with reality. So in the case of someone who has lost a loved one, the statement of denial is: life would be better if my spouse were still here. There may be some truth to this. But this is a fantasy; it will never happen again. The problem with comparing fantasy with reality is that fantasy always wins, because we don't include problems or difficulties in denial fantasies. The two major problems with denial are that the fantasies won't or are unlikely to occur and they end up demeaning the present.

To see how this works, imagine the following scene: A man is sitting with his wife by a mountain lake in the Pocono Mountains at sunset. Then he thinks to himself: if we were rich right now, we could be sitting on the beach of a fabulous Caribbean resort, having waiters bring us rum punches at the snap of our fingers, while watching a spectacular sunset over the Atlantic. It's a nice fantasy, but in that moment he has now tarnished a real moment that he could have been sharing with his wife. And if a pleasant experience like this can be turned into sadness, think about how much worse a sad, anxious, or stressful time can be.

At our Center, we call the act of engaging in the denial, the wishing ritual. Like all OCD manifestations, people without OCD also use this. If you examine your own behavior you may recognize some of the following wishing ritual statements: "There should be an easier way to get over my OCD;" "I have to get rid of this image in my head;" "I can't live with this anxiety;" "If only my boyfriend would be nice to me all of the time." Can you identify the fantasy in each statement?

In the first, the sufferer is comparing the work of ERP to an easy imaginary treatment. In the second, the sufferer is comparing life with the image to life without it. The last two wishing statements aren't exclusive to OCD. In the first, the person is comparing their current life with anxiety to one without it. In the last, the lover is actually imagining a boyfriend who is a different person than the one she has.

In each of the above, the problem with giving up denial is that you have to suffer a loss. Treatment will be hard. You will have to use ERP to learn to live in peace with the image. You will have to coexist with the anxiety. And the lover will have to leave her boyfriend and find herself alone for an unknown amount of time. No one wants to have a loss. However, to stay in denial is to go in an endless circle of not confronting a problem and having it torture you forever.

Mourning is the process of moving from denial to acceptance. You can't do it instantly. For example, we noted above

(continued on page 16)

Spend A Weekend In Therapy

Dr. Reid Wilson, coauthor of *Stop Obsessing* and author of *Don't Panic*, has designed a different type of an intensive treatment program – one that takes a weekend. He talks about it in the following interview.

NEWSLETTER: You have created a two-day intensive treatment protocol. How did you decide on this design? Will you describe it for our readers?

DR. WILSON: There are so many communities in this country without specialists in the treatment of OCD. These people need to be served with whatever resources we can make available to them. I have tried to do this through our book, *Stop Obsessing*, and through our free self-help website, www.anxieties.com. But as you know, this disorder can be tenacious, and the



majority of individuals suffering from OCD need direct contact with a professional. This protocol allows people to travel to North Carolina for a single weekend for brief, symptom-focused treatment in a confidential and supportive environment. I work in a small group of 9 people maximum, all diagnosed with OCD, for 6 1/2 hours each day at our Durham, NC office. During the lunch break and evening break, they will each have assignments to practice the skills we are learning.

We will certainly focus on skill development during the weekend, because this is cognitive-behavioral treatment, the treatment of choice for OCD. But I take a little bit different approach than some other practitioners. I am intensely committed to helping people understand the Big Picture, how OCD generally manipulates their thinking and actions. If you can understand the “game” that OCD plays, then you can invent your own strategies to win back control over your life. That is why a two-day treatment can accelerate people’s progress. When you leave Sunday night, you don’t have to have solved the problem; you don’t have to have wrestled OCD to the ground.

You take with you the critical principles of the treatment approach, plus the experience of applying those principles while you were here. You leave with attitude. You can have a mindset that won’t let OCD bully you anymore, and you have guidelines plus skills that support that frame of mind. I also send directly to the referring professional all our handouts and materials, so that if you are in therapy back home, that therapist can quickly get up to speed on what you accomplished with me.

NEWSLETTER: When will you be doing this weekend therapy? Does it depend on how many people are registered to take part in the group?

DR. WILSON: There is always a group scheduled once every three months. Our next weekends are October 28-29, 2006 and February 24-25, 2007. Anyone who wants to attend needs to ask a health professional (primary physician, psychiatrist or therapist) in his/her local area to sign our referral note. That way we ensure that they have been properly diagnosed with OCD before they arrive.

NEWSLETTER: How is the weekend structured? What will patients do on the first day and the second day?

DR. WILSON: We start with changing your mind. Most people come into treatment believing the content of their worries: if they aren’t careful, something bad will happen. Who would be willing to change their actions if they truly believed that these actions would put them or their loved ones at significant risk? That’s how OCD dominates: by threatening your need for safety. If together we don’t change your mind about that – if we don’t help you see it is a grand manipulation by OCD for the sole purpose of making you doubtful and distressed – then we will fail in the project. Treatment for OCD has nothing at all to do with clean hands, safe children, good driving habits, pure thoughts or properly locked doors. Nothing! That is quite a hard message to believe when you have OCD. But the closer you get to believing it, the stronger is your motivation to use the skills to improve.

There is an art and a science to altering people’s belief systems, and if I didn’t have this much gray hair, I am not sure I could accomplish that task in such a short time. But, like most senior therapists, I have been at this project for awhile, and I’ve gotten

pretty good at it. Nonetheless, out of nine people in the group, probably three will not truly change their minds, which is too bad. These people will get half-way better, and then plateau off, because they continue seeing danger where it doesn’t exist. It is always sad and frustrating for me to be unable to help them finish the project. But at the same time, I am well aware of what a powerful, dominating foe OCD is.

Throughout the weekend we continue to address people’s faulty beliefs as they arise, but we turn to specific skills quickly enough for them to “hit the streets” on their first lunch break with specific assignments based on their personal goals. If they don’t practice during the two days, then it is all just theory, so they are clear that they have to get to work. It is such an honor for me to watch everyone support and challenge each other before, during and after these assignments.

The weekend continues in this fashion – theory, practice, feedback and lessons – until mid-afternoon Sunday. Then we address the problems and strategies of carrying these lessons home, and how to get support from family, friends and professionals for their new plans. Everyone leaves with his/her personal self-help plan for his/her major obsessions and compulsions. Some group members choose to exchange emails and phone numbers to continue supporting each other after they leave.

NEWSLETTER: Who will be doing the treatment? Are any other mental health practitioners involved?

DR. WILSON: I am the treating psychologist. There is no other professional involved.

NEWSLETTER: Where will participants in the two-day treatment stay? Can someone commute?

DR. WILSON: We have directions, a map, and a list of the closest hotels, as well as the application form and referral form, on our website: <http://www.anxieties.com/weekend.php> or on a brochure we mail out. We are ten minutes from Raleigh-Durham International Airport. Local participants can commute.

NEWSLETTER: Will people who are taking medicine for OCD be allowed to participate in this program? Will they be able to continue using their medication?

DR. WILSON: On average, six out of nine

With Dr. Reid Wilson

participants are on medications as they enter the group. Often there is at least one woman in the group who wants to get confident enough in her skills to get off the medication because she is ready to get pregnant. A couple of others have the explicit intention to get off the medications eventually. Others in the group have questions about their medications but don't feel the need to get off them. As the treating psychologist, I have no specific agenda regarding medications. One thing that I will communicate about medications is that sometimes they can work "too well." In cognitive-behavioral treatment, you need to have breakthrough symptoms in order to practice your skills. As you improve, it is possible that the medications, coupled with your new skills, will cause you to no longer have symptoms that trouble you. At that point, you have two choices. You can feel satisfied with your improvement, choose to remain at your current dosage, and then begin the maintenance phase of your treatment. Or, you choose to stop taking your medications in order to discover if you begin having more symptoms again. You then apply your new understanding and skills in that new context. I present those options and leave the decision to the patient and the prescribing physician.

NEWSLETTER: Will you teach the participants cognitive-behavioral therapy and exposure and ritual prevention during the program, or does a participant have to have had prior treatment for OCD?

DR. WILSON: No one needs any prior treatment or knowledge of treatment options to participate. They simply have to be properly diagnosed.

NEWSLETTER: Will there be a physician involved to make decisions about medication?

DR. WILSON: If I believe that a change needs to be made in a participant's medication, I will communicate that to the participant or I will talk directly with the prescribing physician.

NEWSLETTER: Is this a brand new program? How did it develop?

DR. WILSON: This design is new, and I think it fills a void in our treatment options. I have been in practice for 29 years, and have been running groups most of that time. I began running intensive weekend programs when I directed American Airline's

fearful flier's program, called Achieving Flight, some 15 years ago. The successes of that program shaped my thinking about how to influence someone's belief system in a short period of time. In February 2006, I began running two new 2-day treatment groups, this one for OCD and a second one for those with panic disorder and social anxiety disorder. I now do them back-to-back, two weekends in a row.

NEWSLETTER: Has your weekend program been proven effective in trials? Who else uses this type of treatment?

DR. WILSON: We have yet to conduct any research on this current design. I think that is at least a year away, as I am continuing to learn and modify the approach. We have clearly established that the treatment theory, which is cognitive-behavioral, is successful. Several intensive day treatment or residential programs, such as Dr. Fugen Neziroglu's at the Bio-Behavioral Institute and Dr. Alec Pollard's at Saint Louis Behavioral Medicine Institute as well as in-patient units such as Rogers Memorial, Menninger's or the OCD Institute, work intensively with individuals and groups. Our program has a similar intensive structure, but we are quite brief. I believe that we can accomplish as much as a several-week intensive program. So I am strongly focused on helping the participants carry the skills – and the understanding of how to defeat OCD – back home with them in self-help strategies.

NEWSLETTER: What level of OCD are you treating with this program? Moderate or severe?

DR. WILSON: If I am aware that someone is severely incapacitated, I will screen them out of the program. But currently I take this stand: if someone can tolerate the trip away from home, and the separation from their support persons, and if s/he wants to learn about how to win over OCD, then I think the program can be helpful. No one needs to beat OCD in two days. Every opportunity to strengthen yourself will be helpful. What I offer is knowledge, a "how-to" structure for both self-help and treatment, cognitive restructuring, and graded exposure practice, in a confidential and supportive environment. But the central goal is to provide participants with a simple framework that they intellectually understand, and that they can apply to all situations related to OCD in the future. Someone with severe OCD

may make no progress behaviorally in the two days, because they simply aren't ready yet. That outcome doesn't bother me. But I do want them walking out Sunday afternoon saying, "As I build my courage, as I find the support I need, and as I turn up the dial on my willingness to be uncertain and distressed, I now know what actions to take to get stronger."

NEWSLETTER: What is your educational background? Your treatment experience?

DR. WILSON: I have a Ph.D. in clinical psychology. I began my career at the Boston Pain Unit, a 14-bed, 30-day intensive inpatient therapeutic community for chronic pain patients. That state-of-the-art facility was tremendously influential in my career. Data from my research there became my dissertation, and that is where I began developing my theories of how a person can rapidly shift her assumptions about her ability to change. By 1980 I intensified my focus on treating the anxiety disorders and soon published the first edition of my first book on self-help for panic disorder, *Don't Panic*. In 1989, Dr. Edna Foa of the University of Pennsylvania allowed me to collaborate with her on the first edition of our self-help book, *Stop Obsessing*. In most ways I felt more like her student than her co-author, and my grasp of OCD treatment grew exponentially.

NEWSLETTER: Is there insurance coverage available for this program? Will Medicare or Medicaid cover it?

DR. WILSON: Because I am a licensed psychologist, most insurance companies will reimburse for my services. Unfortunately, most plans only reimburse for 90-minute group treatment, so they won't pay 100% of the cost. Fortunately, at \$375 the program is relatively inexpensive, less than \$30 per hour.

NEWSLETTER: To get more information on this treatment, who should be called or e-mailed? Can a potential participant get in touch with you directly or do you want only their treatment provider to call?

DR. WILSON: They can write me directly at 3011 Jones Ferry Road, Chapel Hill, NC 27516. Or email: rrw@med.unc.edu. Or phone: 919-942-0700. We can mail them a brochure, or they can see the full schedule at: <http://www.anxieties.com/weekend.php>. I do not need to talk to their treatment provider, but I do talk to therapists when they want to ensure that this is an appropriate referral. I am always happy to talk directly with anyone.

Mindfulness and Acceptance

(continued from page 12)

that for the death of a loved one, the statement of denial is that life would be better if your loved one were alive. If mourning takes place, you will still miss your loved one. But when you are engaged in some activity, you will enjoy that activity as opposed to thinking about how much better it could be. However, two weeks after losing your partner, no matter how self-aware you are, you will be in denial. You can't stay in denial forever, but there is an upper limit as to how fast you can mourn. Mourning is work.

To go through the work of mourning is to be able to live in the present. Think about someone you love. If they aren't with you at this moment, then they are no more than a memory and a hope, that is, a memory of the good times in the past and a hope they will be alive for the future. The only real time you have them is when you are with them. And, as you know, with OCD, you don't even have that. You are forever in OCD land, wishing your rituals could make the impossible true and that you could know something with absolute certainty.

The first step of treatment is deciding that you want to learn acceptance. We believe that for most forms of OCD, the core is intolerance of uncertainty. Thus, your first goal needs to be wanting to learn how to live with uncertainty. Again, this is a process. You can't just decide that you accept uncertainty, you have to go through the work, the ERP. But if learning to live with uncertainty isn't your goal, then how can treatment work? Remember, the true reason you can't be certain is that for every logical answer there is a "what if." It may be an unlikely "what if," but if you want absolute certainty, unlikely isn't good enough.

To decide to live with uncertainty means you want to learn to live in a world where your worst fears can come true: you may contract a horrible illness, you may cause the death of your family, you might run someone over and not know it, you may be gay, or you might go crazy. The reason for choosing this potentially scary vision is that there is no other; the alternatives are wishes and the problem is that you know this. That is why you go in endless circles. On the other hand, we know you can learn to live with uncertainty, because for all of the parts of your life your OCD doesn't focus upon, you do so. You get in a car, knowing it might crash; and if this isn't your OCD problem, your plan is to deal with it if the crash happens. You risk death just to see a

movie! And if you look at the above feared consequences we raised, you know they are all possible, but you don't care about the ones that aren't your specific OCD fears. The goal of treatment is to help you treat your feared consequences like all of the disastrous consequences that you accept.

Before moving to the role of mindfulness in facilitating acceptance, we would like to suggest a way to encourage you to move towards acceptance, both of the possibility of facing feared consequences and of experiencing the sensations of anxiety that arise during treatment. Think about what you have lost to OCD, but do it in detail. Think about times you have humiliated yourself, about jobs and relationships that were lost, events that you missed. The more painful you can make this the better, because when you are confronted with having to accept the risk of uncertainty and the work of exposure, you will want to remember these to spur you on. In addition, think about the harm you have done to your families with your anger, your forcing them to ritualize, making your children late to events, questioning them endlessly, and whatever else you can think of. These are real. This pain can motivate you to accept the work of treatment, so that you can live without being ruled by OCD. Remember without acceptance, there is no hope of recovery.

In some ways, we have already provided you with the beginnings of a definition of mindfulness. It is living in the present and experiencing only the moment. More specifically, mindfulness means paying attention to the present moment on purpose and without judgment (Kabat-Zinn). Often the only thing wrong with the present is that our minds are elsewhere, worrying about the future in a "normal" way or in an OCD ritualistic way. Or we may even be thinking about something pleasant in the future. Either way, when we do this, we are not in the present. One problem people have when talking about mindfulness is that they assume mindfulness feels good and is pleasant. This isn't true. Mindfulness feels however the real present feels. If I'm sick, it won't feel good. If I'm in an OCD ritual and I'm feeling anxious, the rituals may be in my head, but the unpleasant physical sensations of anxiety are real. The present won't feel good.

For many people, their willingness to learn to accept the possibility of their feared consequences is enough to enable them to go through treatment. However, there is another group of sufferers for whom this acceptance is not enough. They find themselves halted by the intense anxiety they feel during exposure. They will report that it feels like they can't stand another moment. Probably many of you have felt this way at one time or another. Imagine

the worst time you have ever had. How would you feel, if at that moment, we could guarantee that it would only last for 10 more minutes?

Most sufferers report that they feel they could easily tolerate their anxiety if they knew it was only going to last for ten minutes. Think about what this means if you feel the same. In both situations, the first two minutes of the remaining ten minutes or ten hours of anxiety are the same. The reason is that your anxiety has two components: the present experience of uncomfortable sensations and thoughts, and the judgments about these sensations and thoughts. These judgments come swiftly and can often be difficult to tease apart from the present experience itself. They take the form of thoughts such as, "Oh, not again! What if this never ends? What if I'm really going to have a complete breakdown this time? There is no way I can tolerate these thoughts and feelings!" What mindfulness provides us with is a way to see clearly what we are experiencing in the present versus what we are adding to the experience by judging it. It helps us to tease apart what initially feels like an overwhelming wave of anxiety into present moment sensations (heart palpitations, sweating, etc.), present moment thoughts ("I'm shaking!"), "I'm thinking about those violent thoughts."), and the judgmental thoughts about these experiences ("I should not have these thoughts," "Something bad is going to happen if I don't fix this."). In a mindful moment, we will drop the commentary about what we are experiencing and will instead simply notice what we are experiencing, whether this is pleasant or unpleasant.

The work of learning to do this involves practicing in both stressful and non-stressful times. Perhaps the most successful way of learning mindfulness in a non-stressful situation is practicing mindfulness meditation. Mindfulness meditation is not a technique used to relax anxiety away. Rather, the goal of this practice is to learn to focus on your physical and cognitive present without judgment. "What am I feeling now," as opposed to "Am I feeling what I am supposed to be feeling" or "This would be better if..." Learning to do this takes time and patience; practicing mindfulness through mediation during times that are not necessarily stressful allows you to be better prepared to apply mindfulness techniques during specifically anxious moments. You are not suppressing judgmental thoughts, but you are focusing your attention upon the present and allowing judgmental thoughts to be noise in the background in the same way you focus upon a conversation you are having in a restaurant despite the fact you can hear others talking.

The next step would involve setting up a small exposure and then using mindfulness to focus on all the physical and cognitive components of your anxiety without judgment. Again, this does not mean suppressing thoughts nor does it mean reasoning them away. More important, the goal is not to get rid of your anxiety. It is to learn to be able to stay with it and function with it. Imagine someone you loved needed you to rush him or her to the hospital in a life or death situation. We are assuming you would rather be in the middle of an OCD mess than in the actual emergency. However, in which one would you better cope with your anxiety? For most people the answer is the emergency. They may feel anxious and panicked, but they allow those feelings and instead focus on the job at hand. If they are worried, it is about their loved one, not their feelings. You would actually cope better in the situation that you don't want to be in. This is because you are accepting your anxiety and functioning side by side with it rather than fighting it. The fact that you don't like it doesn't interfere. The practice of mindfulness will help you become better able to do this in any given moment.

Coping with anxiety this way is not the same as saying just put up with your anxiety and suffer. Instead you are working on getting rid of another wishing ritual. In this case, you are accidentally saying that life without this anxiety would be better and as a result are comparing every moment to the fantasy moment in which anxiety doesn't exist. Remember, whenever you do this, you are making the present worse. By using mindfulness as a way to expose yourself to living with anxiety, your willingness to tolerate anxiety changes and your judgments change from "this is intolerable" to "I don't like this, but I can get through this and not have it control me."

In the end, all of us only have the present. Without acceptance, we are trapped in a fantasy world that ruins us. Mindfulness helps us to remain in the present and to experience it even when it is unpleasant. Initially, this sounds crazy, but the willingness to stay in the present allows us to cope with the moment rather than making it intolerable. Obviously a short article can't teach you all there is to know about these concepts or how to implement them. If it were that easy and involved so little work, all of you would have already done this. We do hope that the ideas we've presented to you will help to change the way you approach treatment, so that you can reach the goal of freeing yourself from the chains of OCD, enjoying the life you have and working to improve your life in all of the ways that will make it full.

Bulletin Board

(continued from page 2)

OCD EXTINCTION STUDY (UCLA)

The purpose of this study is to evaluate the optimal method by which exposure therapy is conducted for obsessive compulsive disorder and includes the use of a new drug that has been considered to be effective in enhancing learning, D-cycloserine. Participants for this study must have obsessive compulsive disorder (OCD) with fears of contamination and will receive a free research evaluation of their OCD. Participation involves 7 study visits (3 of which are for exposure therapy in which participants are encouraged to repeatedly face feared objects or situations). The other visits are for assessment purposes, pre-treatment, post-treatment and follow-up. There is no compensation for this study and parking is not reimbursed. If you are interested in participating in the study, or finding out more about it, please call: (310) 794-1038.

OCD TREATMENT STUDY FOR CHILDREN AND ADOLESCENTS

If your child or teen (ages 7-17) is suffering from Obsessive-Compulsive Disorder he or she may be able to participate in a research study at the National Institute of Mental Health in Bethesda, MD. We are investigating the medication riluzole which has been reported to benefit adults with OCD or depression. We expect that riluzole will decrease obsessive compulsive symptoms in children and adolescents.

Children with a primary diagnosis of OCD, who reside within commuting distance of Bethesda, MD, may be eligible. Children will receive a one-day comprehensive psychiatric and medical evaluation, and follow-up visits every two weeks for 3 months, and at 4, 6, and 12 months. There is no charge to participate; travel assistance is provided.

Dr. Paul Grant, MD, a child and adolescent psychiatrist, is the Principal Investigator. For further information please contact Lorraine Lougee, LCSW-C at 301-435-6652 or Matthew Hirschtritt at 301-496-5323, or email OCDNIMH@intra.nimh.nih.gov.

National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services.

PERCEPTUAL STUDY IN BDD, OCD AND CONTROLS

At the Bio-Behavioral Institute we are studying how accurately OCD and BDD patients perceive their appearances. A computerized program is utilized in this study. As part of the study, participants who are interested in finding out how they think, feel and perceive their looks, would be photographed at the Institute and will have to answer a few questions. It will require about 30-60 minutes of their time. Feedback will be provided. Anyone interested, please call Natalie at (516) 487-7116.

NEW HOARDING THERAPY GROUP

Are you not able to part with anything, including the most useless junk, telling yourself, "I might need it someday?"

Does your home resemble a warehouse?

Have you pretty much given up hope in obtaining help for your problem?

Are you really motivated to do something about your hoarding?

The Hoarding Therapy Group will provide both support and treatment. Individualized treatment plans are tailored to the needs and capabilities of each participant; de-hoarding assignments are manageable. Feelings relevant to the hoarding experience are explored. Guest speakers will be periodically scheduled.

For further information, contact Stacie Lewis, LCSW, at (212) 568-9570 (Manhattan, NYC location).

DECIDING BETWEEN RIGHT AND WRONG

What is your moral sense? Researchers at Harvard University are interested in how people decide between right and wrong. Your participation is very important to this project. If you wish to participate or just learn more, please log on to: <http://www.harvardcogevlab.org/MST/OCF/demographics1.php>

FREE COGNITIVE BEHAVIORAL TREATMENT FOR CHILDREN AND ADOLESCENTS WITH OBSESSIVE COMPULSIVE DISORDER IN THE SAN FRANCISCO BAY AREA!

We are seeking children and adolescents aged 7 to 17 with OCD who have not had cognitive behavioral therapy (CBT) for OCD before.

- Our study will test a new way to learn and do CBT using technology.
- There are no charges for the therapy or being in the study.

If you are interested, please contact Margo Thienemann, M.D., at mthiene@stanford.edu or 650-723-5383 or Sarah Forsberg at sarah523@stanford.edu.

Bulletin Board

(continued from page 17)

For further information regarding questions, concerns, or complaints about research, research related injury, and questions about the rights of research participants, please call 650-723-5244 or call toll free 1-866-680-2906 or write the Administrative Panel on Human Subjects, Medical Research, Administrative Panels Office, Stanford University, Stanford, CA 94305-5401.

UNIVERSITY OF FLORIDA RESEARCH STUDY

Do you repeatedly check or arrange things, have to wash your hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your mind, such as, concerns with germs or dirt or needing to arrange things "just so"?

If this sounds familiar, you may have a treatable problem called obsessive compulsive disorder (OCD). Past research has found that a form of therapy, namely, cognitive-behavior therapy, is helpful in as many as 85% of people with OCD. Researchers at the University of Florida are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of cognitive-behavior therapy in adults with OCD.

To be eligible, you must be at least 18 years old. If you participate in this study, you will be randomly assigned, that is, by chance, as in the "flip of a coin," to receive either the study medication (D-Cycloserine) or a sugar pill in addition to being seen in therapy. The therapy will be held weekly (90 minutes each session) for 12 weeks (12 total sessions). There will also be nine psychiatric evaluations that take place. Three of these evaluations will be comprehensive and take about 2 1/2 hours each (immediately before and after treatment and three months later). Six will be short and take place once a week during therapy (25 minutes each). You are responsible for the cost of therapy. Study medication and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time.

If interested, please contact Dr. Eric Storch at (352) 392-3611 or estorch@psychiatry.ufl.edu.

This study is funded by the OCF Research Fund.

OCD AND HOARDING STUDY

The Institute of Living in Hartford, CT and The Boston University School of Social Work are conducting research to understand the features of obsessive compulsive disorder and compulsive hoarding. The study compares people with hoarding problems to those who have obsessive-compulsive disorder (OCD). It is not necessary for participants to have hoarding problems or clutter to participate. The researchers hope to learn more about why hoarding and obsessive compulsive symptoms develop, how these problems are related to other psychiatric disorders and how best to assess these problems. This information may be helpful for identifying effective treatments in the future. Researchers are looking for people age 18 or older who have (1) problems with excessive clutter or (2) obsessive-compulsive disorder and, (3) live within forty minutes of the greater Hartford or Boston area. The study consists of a 4-hour diagnostic interview about anxiety and mood symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the clinics. Additionally, the study will include a 1-hour visit to the participant's home where the participant will take part in an experimental task about removing clutter and another task about acquiring new items. Participants will also have a chance to take part in a discarding and acquisition task. Participants will be paid \$20/hr for their time and can make up to \$180.

If you are interested in participating and have any questions, please contact Jessica Rasmussen, B.A., at Boston University at (617) 358-4213 or (617) 353-9610 or Buck Brady, B.A., at The Institute of Living in Hartford, CT at (860) 545-7574.

A FAMILY RESEARCH PROJECT

Who? We are a research team from The Johns Hopkins Hospital who are interested in studying family functioning in different groups of children between the ages of 6-17 years.

What? To study family functioning of children and adolescents with obsessive-compulsive symptoms and those without symptoms.

Where? In your own home. No hospital or school visits are necessary.

How? (Parent) A phone interview regarding your child's behavior and daily functioning as well as your relationship with your child. Paper and pencil questionnaires regarding aspects of family functioning.

(Child and adolescent) A phone interview regarding his/her behavior and daily

functioning. Questionnaires regarding his/her relationship with you and his/her personality.

Compensation? Your child will be given a \$15 gift certificate to a book store in exchange for participation. This will be given after all questionnaires and interviews are completed.

How to Join this Research? Call us at 443-287-2292 or e-mail Marco Grados, M.D., M.P.H., at MJGrados@jhmi.edu and let us know if you are interested in participating and when we can reach you.

Your participation will help us understand family functioning in children and adolescents with OCD. Principal Investigator: Marco Grados.

ANSWER OUR CALL FOR CONFERENCE PRESENTATIONS

The 14th Annual Obsessive Compulsive Foundation Conference is scheduled for July 20 – 22, 2007, in Houston, TX. Anyone interested in putting on a seminar, workshop, presentation or support group must submit his/her presentation proposal to the Conference Committee by January 31, 2007.

Past OCF conferences have offered workshops and presentations on the etiology and genetics of OCD, exposure and response prevention therapy, cognitive-behavior therapy, medication management, treatments for symptom specific OCD, compulsive hoarding, family therapy, treatment resistant OCD, PANDAS, OC spectrum disorders, motivational interviewing, mindfulness, acceptance and commitment therapy, and new and emerging research. There have been different support groups including the GOAL support Group, the OCA support group, and mutual groups for both parents and people with OCD.

We invite and encourage clinicians, researchers, sufferers and caregivers to submit proposals that will interest attendees and broaden the understanding of OCD.

For more information, please contact Jeannette Cole, Deputy Director, at (203) 401-2069 or email her at cole@ocfoundation.org for an application.

SUBMISSION DEADLINE IS JANUARY 31, 2007.

Compliance with Solicitation Regulations

The Obsessive Compulsive Foundation, Inc. ("OCF") is a Connecticut not-for-profit corporation. Its mission is to educate the public and professional communities about Obsessive Compulsive Disorder ("OCD") and related disorders; to educate and train mental health professionals in the latest treatments for OCD and related disorders; to provide assistance to individuals with OCD and related disorders and their family and friends; and to support research into the causes and effective treatment of OCD and related disorders. The OCF's principal place of business is 676 State Street, New Haven, Connecticut 06511-6508. The information enclosed herein describes one or more of the OCF's activities. Your gift is tax deductible as a charitable contribution. Contributions received by OCF do not inure to the benefit of its officers, directors or any specific individual.

A copy of OCF's most recent financial report is available upon request and may be obtained at no cost by writing to OCF at P.O. Box 9573, New Haven, Connecticut 06535-0573 or by contacting its Executive Director at (203) 401-2074. If you are a resident of one of the following states, you may obtain information directly as follows: **Florida:** A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL FREE WITHIN THE STATE (800) 435-7352, OR (850) 488-2221 IF

CALLING FROM OUTSIDE FLORIDA. OCF'S REGISTRATION NUMBER IN FLORIDA IS CH8507. **Maryland:** A copy of the documents and information submitted by the OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, MD 21401, Telephone (401) 974-5534. OCF's registration number in Maryland is 5015. **Mississippi:** The official registration and financial information of OCF may be obtained from the Mississippi Secretary of State's office by calling (888) 236-6167. OCF's registration number in Mississippi is C1143. **New Jersey:** INFORMATION FILED WITH THE ATTORNEY GENERAL CONCERNING THIS CHARITABLE SOLICITATION MAY BE OBTAINED FROM THE ATTORNEY GENERAL OF THE STATE OF NEW JERSEY BY CALLING (973) 504-6215. OCF'S REGISTRATION NUMBER IN NEW JERSEY IS CH1461800. **New York:** A copy of the most recent annual report filed by OCF with the New York Secretary of State may be obtained by writing to Charities Bureau, 120 Broadway, New York, NY 10271, Telephone (518) 486-9797. OCF's registration number in New York is 66211. **North Carolina:** A COPY OF THE LICENSE TO SOLICIT CHARITABLE CONTRIBUTIONS AS A CHARITABLE ORGANIZATION OR SPONSOR AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DEPARTMENT OF HUMAN

RESOURCES, SOLICITATION LICENSING BRANCH, BY CALLING (919) 733-4510. **OCF'S REGISTRATION NUMBER IN NORTH CAROLINA IS SL002059.** **Pennsylvania:** A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, (800) 732-0999. OCF's registration number in Pennsylvania is 15687. **Virginia:** A copy of the OCF's most recent financial statement is available upon request from the State Division of Consumer Affairs in the Department of Agriculture and Consumer Services. **Washington:** Additional financial disclosure information may be obtained by contacting the Secretary of State toll free, within Washington, at (800) 332-GIVE. OCF's registration number in Washington is 6363. **West Virginia:** West Virginia residents may obtain a summary of the registration and financial documents from the Secretary of State, State Capitol, Charleston, West Virginia 25305. **REGISTRATION WITH A STATE AGENCY DOES NOT CONSTITUTE OR IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THAT STATE.** THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PERCENT OF EVERY CONTRIBUTION IS RECEIVED BY THE OCF. DONATIONS WILL BE USED TO UNDERWRITE THE OCF'S PROGRAMS, ACTIVITIES AND OPERATIONS AS WELL AS FOR RESEARCH.

Name _____

Address _____ City _____

State _____ Zip _____ Telephone (_____) _____ Email Address _____

- Please renew my membership in the OC Foundation
- I wish to become a member of the OC Foundation
- \$45 Regular Member (Canadian US \$50, Overseas US \$55) \$65 Family Membership (Canadian US \$70, Overseas US \$75)
- \$85 Professional Member (Canadian US \$90, Overseas US \$95) **Additional Donation \$ _____**
- Matching gifts from your employer (please enclose forms)

Credit Card Payment Authorization: For your convenience, we accept Visa, MasterCard, American Express and Discover.

Please check method of payment : VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Credit Card # _____ Expiration date _____

Amount \$ _____ Signature _____ Date _____

Please enclose payment. Checks should be made payable to OCF, Inc. and mailed to:

OCF, P.O. Box 9573, New Haven, CT 06535

Telephone: (203) 401-2070 Fax: (203) 401-2076 E-mail: info@ocfoundation.org

ADDITIONAL DONATIONS TO SUPPORT OCF'S WORK ARE GRATEFULLY ACCEPTED.

You may photocopy form to keep your Newsletter intact.

www.ocfoundation.org

Time-Sensitive Material — DO NOT DELAY!

Address Service Requested

P.O. Box 9573
New Haven, CT 06535



Non-Profit
U.S. Postage
PAID
New Haven, CT
Permit No. 337