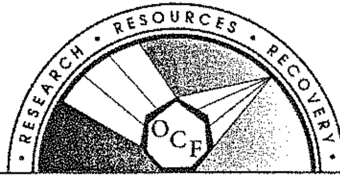

OCD Newsletter

Published by The OC Foundation, Inc. to Expand Research, Understanding, and Treatment of Obsessive-Compulsive Disorder

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

Loves Me? Loves Me Not?

by Fred Penzel, Ph.D.

"I really care about my wife," my new patient Ed told me, "but I just can't get this idea out of my head that I don't actually love her." Ed was a fifty-one year old successful businessman and entrepreneur. Over the last two years he had been increasingly troubled by repetitive thoughts about his wife not being "the right one" for him, that he would never be happy with her, and that unless he left her, he would forever feel trapped in this unhappy relationship. He would stare continually at other women as a way of double-checking to see if he found them more attractive than his wife. As he looked, he wondered, "Do I have to leave her because she isn't attractive enough for me, or because these other women look *more* attractive?" This staring had gotten him into difficulties on several occasions. He and his wife have two children and their marriage had always been a generally happy one. He felt very isolated with these thoughts, and had never shared them with his wife.

Another patient, Maria, was having a somewhat different experience. The 32-year old school teacher related, "I can't stop thinking about my fiancee's *last* girlfriend. I keep asking him over and over if she was mean to him, and also about why they *really* broke up. I have this idea that I don't have the whole story. I can't stand not knowing.

Maria had been relentlessly hounding her boyfriend to discuss these topics day and night. She had no hesitation about calling him at 3 am to question him one more time. This had led to an escalating level of arguments, and a refusal on his part to discuss the subject with her any further.

They were on the verge of breaking up when she decided to go for help. She felt distressed that she could not prevent herself from constantly bringing up these nagging questions, even though she realized what the consequences were. *(Continued on page 11)*

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- The Right Stuff (continued)

Jenike Urges Financial Support For Research

Dear Friends:

For the last few years, I have been making an annual plea to members of the OCD community to help us by making donations to the OC Foundation to support research efforts. Without further high quality research, we will be stuck in our current state of affairs with partially effective treatments for most patients and no effective treatment for a few patients.

The fact that so many of you are forced to live a life that is diminished in quality, productivity, and enjoyment is tragic. I have been working in the OCD area for over two decades, and I have clearly seen how research can benefit you and your loved ones. Without high quality research, we would not have the amazing medications on the market. We would not know of the benefits of cognitive behavior therapy or how to best utilize these approaches to maximize the quality of your lives.

There are other disease specific organizations that have been remarkably successful in attracting research funding, and these groups are rapidly advancing understanding of their respective illnesses. Unfortunately, the OC Foundation has lagged far behind other organizations in fundraising. For example, the Tourette Syndrome Association raises many times more money than the OC Foundation, even though Tourette's Disorder is much less prevalent than OCD.

As I have noted in the past, many of the world's best researchers decide to study particular disorders based on the availability of funding. If we are going to push OCD research to the forefront, we need to be able to offer more research dollars to investigators. The last few years, the TOTAL amount that we have given out yearly to support

(Continued on page 3)

Lifescape Chat With Surgeon General David Satcher, M.D., Ph.D.

In response to the Surgeon General's Report on Mental Health, Lifescape held a forum where the audience was encouraged to ask Dr. Satcher to respond to issues raised by the Report. The following are excerpts:

Guest: Isn't the media a major cause of stigmatizing the mentally ill by how it describes people who commit heinous crimes indiscriminately as "mentally ill"? What can you do to educate/sensitize the media?

Dr. Satcher: We try to make it very clear that the mentally ill, when looked at objectively, are no more violent than other people. But when the media report, the impression often given is that the mental illness is what led to the attack, and that this is something to be expected of the mentally ill. We try to make it clear that mentally ill people who are receiving treatment are no more violent than others and commit no more violent crimes. In other words, the myth of violence in mentally ill is one of the things we will attempt to deal with in this report.

Guest: Will there be any funding in the future for mental health research? Also, what can we do at the grassroots level to help remove the stigma of mental illness?

Dr. Satcher: First let me say clearly, we expect there to be increased funding for mental health research. There's already funding, but we expect there to be increased funding because our department has a major mental health initiative, and are therefore submitting a request for additional funding for research and services. People at the grassroots level can help educate, as knowledge is our Number One weapon. If the information is to be effective, the information needs to get to everyone. We need an organized campaign to deal with stigmatization relative to mental illness and need to use media effectively the way they did in Australia in their destigmatization campaign. There is no substitute for what people can do in their own communities, churches, clubs, making the topic one of ongoing discussion is what is needed.

Guest: What is the intent of the report? Awareness or seeking specific actions? How close are we to getting laws requiring mental health insurance to equal major medical coverage?

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THIS NEWSLETTER WAS FUNDED IN PART BY AN UNRESTRICTED EDUCATIONAL GRANT FROM PFIZER, INC.

What is thought Suppression?

by Jonathan S. Abramowitz, Ph.D.

The mind is a curious thing. While it seems to us that we *should* be able to choose what we think about, most people (with and without OCD) actually find it quite challenging to control the focus of their thoughts. Especially for people with OCD, whose unacceptable thoughts often run rampant, this struggle for control is often anxiety-provoking, and is resolved only after a high emotional price has been paid. The "thought suppression paradox" can be used to help understand and treat OCD.

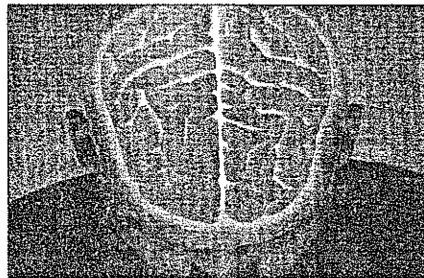
Psychologist Daniel Wegner and his colleagues conducted a series of experiments in the 1980's that contributed valuable information to how we think about various behavioral disorders, including OCD. Wegner's experiment went something like this: Participants were divided into two groups. The first group was told to purposely think about a *white bear*. Members of the second group were instructed to do the opposite: "think about anything you'd like, but *do not* think of a white bear." Wegner then asked his subjects to record their thoughts over a five-minute period and ring a bell any time they had a white bear thought. What do you think the researchers found?

You might have figured this out for yourself if you've ever tried to stop thinking about something. This futile exercise is called "thought suppression." In Wegner's initial experiment, participants who tried to suppress white bear thoughts later ended up reporting *more* thoughts about white bears. Similar studies have also found that purposely trying not to have certain thoughts seems to result in our thinking the exact thought we were trying to ignore.

This paradoxical phenomenon has come to be known as the "rebound effect." In more recent studies, psychologists have used the rebound effect to help understand why depressed people have difficulty overcoming depression, why people with post-traumatic stress disorder (PTSD) have recurrent thoughts about disastrous events in their lives, and why people who constantly worry have difficulty getting their minds off their concerns. But of special interest is the relevance of thought suppression to obsessions in OCD.

How does the rebound effect relate to OCD? By definition, obsessions are unwanted intrusive thoughts, ideas, or images that are unpleasant and actively resisted. For example, people with obsessions about hurting loved ones become distressed when they have such thoughts. It is not surprising, then, that the people do attempt to suppress obsessional thoughts. In fact, studies have shown that people with OCD spend a lot of time and energy trying to suppress unwanted thoughts.

In contrast, people without OCD are somehow able to dismiss their upsetting thoughts without paying too much attention to them. Thus, for people with OCD, thought suppression becomes a mental coping strategy or habit, an automatic response to an unpleasant thought.



The problem is, as Wegner and his colleagues found, it is virtually impossible to suppress thoughts. In fact, trying to suppress an obsessional thought probably results in a surge of more unwanted thoughts, and consequently, more distress. So, by repeated attempts to suppress negative unwanted thoughts, the person with OCD starts a downward spiral of suppression, more thoughts, distress, suppression, etc. It becomes a constant battle for mental control – a battle that is nearly always lost.

The question that needs to be answered here is: "What is the *consequence* of not being able to control thoughts?" Although people in general have difficulty controlling their thoughts, there are probably important differences between those with and without OCD in terms of how they cope with this reality. People with OCD are highly influenced by their thoughts and misinterpret failures in thought suppression as significant or catastrophic. They think that having a certain thought means bad things will happen; or if I keep thinking it, it *must* really be true, or my frequent bad thoughts mean I might *do* something "bad." These types of thoughts characterize a phenomenon known as *thought-action fusion*. This is the mistaken belief, or doubts that our negative thoughts might somehow influence the world, or cause us to do things that we don't want to do. Studies have found that people with OCD often show this type of thinking.

Putting this Knowledge to use in Treatment

Knowledge of the thought suppression phenomenon is very useful for a therapist using cognitive behavioral therapy to treat OCD. First, many clients find it helpful to know about thought suppression because it helps to have a logical and scientifically valid explanation for seemingly scary recurring obsessional thoughts. I find that many people with OCD come to therapy believing that there is something dreadfully wrong with them because they can't stop thinking thoughts they believe are unacceptable.

To teach patients that bad thoughts don't make them "bad" people, and that it is simply efforts to suppress that lead to more thoughts, I often ask clients I work with to conduct a short experiment in my office. I instruct them *not* to think of a *pink elephant* for a minute or two. When I ask them what they thought about, they report, without fail, that their mind was filled with pink elephant thoughts. Then we discuss the very points I described above. A discussion of the paradoxical effects of thought suppression is often comforting to clients who,

until then, were certain that they were "being punished" or "cursed" with negative thoughts they could not stop.

Understanding the thought suppression paradox also helps clients to more clearly see the rationale for doing exposure therapy. It is important to discuss how thoughts are *not* the same as actions, and that a person can think anything they want (e.g., fantasies, dreams) without ever harming or wanting to harm anyone. Correcting thinking mistakes related to thought-action fusion is an important part of cognitive-behavioral therapy for OCD. Exposure practices (the most important part of cognitive-behavioral therapy) often include purposely having negative thoughts without trying to suppress them. I often tell clients to invite the unwanted thought into their minds to *have a cup of coffee*. For example, if a client tells me he keeps having the thought that he might have run over someone with his car, I instruct him to *purposely* imagine that this has really happened. Then I tell him to elaborate on the thought, instead of trying to avoid it. Repeating this type of *imaginal exposure* exercise helps clients to (1) become less afraid of their obsessional thoughts, and (2) learn that they can have such thoughts (even truly awful ones) without anything terrible happening to themselves, or anyone else. Thinking about it doesn't make it true.

Clients who practice this type of imaginal exposure are often able to change the way in which they interpret the presence of unacceptable thoughts. Instead of believing that every occurrence of such a thought is significant, they are able to correctly recognize that sometimes, people have such thoughts. But that these thoughts are harmless and do not require wasteful responses such as rituals or attempts to suppress. Thus, exposure helps clients to view their upsetting ideas as a normal part of life, and not a sign of disaster. Once this lesson is learned, a client no longer attempts to suppress bad thoughts, and he often reports fewer and fewer intrusive thoughts.

The thought suppression phenomenon illustrates some of the interesting cognitive facets of OCD. From my perspective, it demonstrates an understanding of OCD that is an advance over simply labeling this complex disorder as a "neurobiological disease." It gives us a greater understanding of the complexity of the disease, and opens the way for us to learn more about how biological and environment factors interact to develop and maintain obsessions and compulsions. This, in turn, will help with the ultimate goals of ameliorating such problems.

Jonathan Abramowitz, Ph.D., is with the Center for Treatment and Study of Anxiety at the University of Pennsylvania. He can be reached by e-mail at: abramow2@mail.med.upenn.edu.

LIFESCAPE CHAT

(Continued from page 1)

Dr. Satcher: I think the intent of the report is to lay a foundation on which action can be built. On the basis of these reports, many recommendations and policies will be made. Already, we're seeing people introduce bills in state legislatures for parity. We expect lots of action to come from this report, especially if history is an indicator. In the last chapter of the report, we tried to make very clear what policy changes are needed. We mentioned eight areas, such as the need for a science base and more funding , the need to overcome stigma and strategies, the need to improve awareness and nursing, more personnel and the need to ensure the delivery of state-of-the-art treatment.

Guest: Primary care physicians could be the first line of defense but they seem very unprepared or reluctant to deal with neurological, emotional and mental illnesses. Please comment on this.

Dr. Satcher: We made it clear in the report that primary care physicians have a critical role to play in providing access to mental health services. In our visit to Australia in November, it was very clear there that primary care providers were the major providers of services, even though they worked closely with psychiatrists, just by the number of patients they saw. In this country, as there, it is clear that primary care providers need more sensitivity, more awareness, more training in recognition, diagnosis and treatment. One of the things we pointed out in the call to action for suicide prevention was that 70 percent of the elderly who committed suicide had been seen by a physician within a month prior to the suicide. It raises questions to the extent that primary care doctors are listening, asking questions and intervening appropriately. I believe we'll see a lot of progress in this area.

In closing, we have much more to learn, because as of now we actually know more about mental illness than mental health. It's really important that we understand better how to prevent mental illnesses and their complications. I'm hoping that future research will focus on mental health promotion and prevention of mental illness. But we already know enough to change the environment from one of stigmatization and blame to one of caring and support.

We already know enough to organize mental health services in such a way that there is a comprehensive, seamless range of services from home care to community facilities to institutions for people who need them. It's critical that those services be well coordinated and that people are not allowed to fall through the cracks. And we certainly already know enough to know that there is no justification for the disparity and discrimination that now exists in the provision of mental health services. There's no scientific justification for that.

So given all that we know, it is time for us to move forward together. I look forward to working with all of you.

JENIKE URGES FINANCIAL SUPPORT FOR RESEARCH

(Continued from page 1)

research has been significantly less than $100,000. This is an astoundingly microscopic figure when you estimate that between 6,000,000 and 8,000,000 people in the United States suffer from OCD. This calculates out to a donation rate of one to two cents per person. If everyone with OCD gave $1 for research, we would have six to eight million dollars for research. This figure would really make a difference!! Unfortunately, only a very small minority contribute anything to research.

Since we have offered funding for research, we have had over 50 high quality proposals submitted each year, but we have only been able to fund five or less each year. Unfortunately, if we are only able to fund fewer than 10% of the proposals, interest will evaporate and researchers will go elsewhere.

The OC Foundation desperately needs your financial assistance to ensure that OCD patients can live their lives to the fullest. All gifts are fully tax deductible.

I thank you sincerely for any financial assistance you can offer.

Michael A. Jenike, MD, Professor of Psychiatry, Harvard Medical School can be reached by email at: jenike@psych.mgh.harvard.edu.

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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The Obsessive-Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 10,000 members worldwide. It's mission is to increase research, treatment and understanding of obsessive-compulsive disorder (OCD). In addition to its bimonthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to registered treatment providers; and the distribution of books, video's, and other OCD-related materials through the OCF bookstore and other programs.

Bulletin Board

Participants Sought

Do you have OCD and live within commuting distance of Philadelphia, Pennsylvania? You may be eligible to receive **free cognitive-behavioral therapy (CBT) or pharmacological treatment.** We are looking for adult and child participants for several studies of SSRIs (including Anafranil/clomipramine) and CBT. For details on the study, call Matt Sacks or Edna Foa at the University of Pennsylvania's Center for Treatment and Study of Anxiety at (215) 746-3327. Or send e-mail to: sacksm@mail.med.upenn.edu.

Do you have religious obsessions or compulsions? Do you repeat prayers, religious rituals, confessions or ask clergy to reassure you about religious matters? The Center for Treatment and Study of Anxiety at the University of Pennsylvania **is developing a cognitive-behavioral treatment program for teens and adults with "scrupulosity" (religious OCD symptoms).** If you are within commuting distance from Philadelphia, PA, you may be eligible to participate in this study. For further information, call Dr. Jon Abramowitz or Dr. Edna Foa at (215) 746-3327, or send e-mail to abramow2@mail.med.upenn.edu.

The University of Cincinnati, Dept. of Psychiatry, is conducting a research study on Obsessive-Compulsive Disorder. **The study is designed for individuals with OCD, who have not successfully responded to drug therapy.** Are unwanted, irrational or horrible ideas, images or impulses distressing you? Are there things you do excessively or thoughts you think repeatedly to feel comfortable? Do you worry excessively about cleaning, orderliness, morality, hoarding, seeking assurance, counting, contamination, or checking? If you answered YES to these questions, and you are between the ages of 18-55, **you may be eligible to participate in a research study designed to evaluate a new treatment for Obsessive-Compulsive Disorder.** For more information, call Ladonna Baines at (513) 558-5512. All inquiries are kept strictly confidential.

Individuals who developed OCD before age 15 years are needed for interviewing and blood sampling. Subjects must have a sibling or second-degree relative with OC symptoms who is available for interviewing and blood sampling. Participants must be at least five years old. No treatment is provided, but participants may be taking medication or receiving other forms of treatment during the study.
All participants will be paid; the study has been approved by the University of Michigan Institutional Review Board. For more information, please contact Kristin Chadha, M.S.W. at (kchadha@umich.edu) or Gregory Hanna, M.D. at (ghanna@umich.edu) at Tel: 734-764-0250 or Fax: 734-936-8907.

Columbia University, Dept. of Clinical Psychiatry, a research study funded by *OCF Research Fund* support, is **seeking participants for its study investigating the serotonin transporter in OCD patients.** Medically healthy participants must be able to travel to New York City, currently not taking psychiatric medications, not have major depression, and not have a history of severe substance abuse, or mania. Subjects will be compensated financially for their participation. Interested individuals should contact Dr. Blair Simpson at (212) 543-5367.

A research study is now being conducted at The Institute for Bio-Behavioral Therapy and Research in Great Neck, NY. The study offers **low cost treatment for individuals with Body Dysmorphic Disorder (BDD).** Treatment will consist of 10 weeks of individual cognitive and/or behavioral therapy. If you or someone you know might have BDD and are 18 years of age or older, please contact Sony Khemlani at (516) 487-7116 for more information.

We need your help: We want to know how you helped your adult child with OCD to enter treatment, so we can tell others.

One of the most difficult questions we are constantly asked is, "How can I convince my reluctant adult son or daughter with OCD to enter treatment?" We want to know what you did that convinced your "resistant" son or daughter to take the risk and enter treatment. What worked? Please send your success stories or suggestions to: Newsletter Editor, What Works, OCF, P.O. Box 9573, New Haven, Conn. 06535.

Personal Stories about Behavior Therapy for Obsessive Compulsive Disorder

We are looking for individuals with OCD who would be willing to share their personal experience going through behavior therapy. The stories are going to be used in a book to help people understand behavior therapy. Participation in the project would involve filling out a questionnaire and possibly participating in an interview. The information that you give will be anonymous and with your consent may be selected for publication. If interested, please contact Dr. Christina Taylor or Dr. Diane Sholomskas at (203) 372-4593 or email at taylorc@sacredheart.edu.

Obsessive-Compulsive Disorders Institute to Begin Fast Track Program

The Massachusetts General Hospital OCD Institute located on the grounds of Mclean Hospital in Belmont, Massachusetts, seven miles west of Boston, is a residential program featuring behavior oriented treatment with medication to treat OCD. It opened in 1997. During that period, in addition to treating a majority of patients with very complicated, refractory OCD, the Institute has also treated a number of patients who came to the Institute with the goal of working very intensively on a particular OC symptom which they needed to bring under control in a short period of time so that they could resume their job or schooling. Beginning in January, 2000, the MGH-OCD Institute will begin an intensive Fast Track treatment program within its residential program for OCD patients. If you or someone you know might benefit from a short-term, residential, intensive behavioral program; and are highly motivated to work intensively to rapidly achieve very specific treatment goals, contact the Program Manager, Diane Baney, RN, MBA at 617-855-3279. The Fast Track Program is under the clinical direction of Drs. Michael Jenike and Lee Baer, and William Minichiello.

Obsessive-Compulsive Anonymous (OCA) has a website:

http://hometown.aol.com/west 24th
The web site describes the OCA program and lists the various chapters throughout the US, Canada and now in Germany, (over 35 now & growing) along with contact names and telephone numbers. They also contain interesting links to many other recovery groups and mental health web sites.

The Menninger Clinic in Topeka, Kansas offering two outstanding programs of interest

1) Treating Obsessive-Compulsive Disorders in Children and Adolescents featuring John S. March, M.D., MPH, Duke University Medical Center
Dates: February 4-5,2000
Credit: 12 hours
Fee: $215 per person; $195 each for 2 or more from same agency; $165 school personnel
Location: The Menninger Clinic, Topeka, Kansas

Contact: Menninger Continuing Education, PO Box 829, Topeka, KS 666-1-0829, tel: 800-288-7377, fax: 785-273-9941.

2) The 8th Annual Learning Disabilities Conference: "Meeting the Educational Challenge of Complex Disorders (Tourette's, OCD, ADHD) featuring Sheryl K. Pruitt, MEd, Parkaire Consultants for Neurologically Impaired Individuals, Marietta, Georgia
Dates: March 3-4, 2000
Credit: 9 hours
Fee: $215 per person; $165 school personnel
Location: The Menninger Clinic , Topeka, Kansas
Contact: Menninger Continuing Education, PO Box 829, Topeka, KS 66601-0829, 800-288-7377, 785-273-9941 (fax).

Symposium: MI in the Classroom

A Symposium, "Mental Illness in the classroom, How to Recognize it and Who Can Help", is being held on Saturday, March 11, 2000 from 9:00 am to 5:00 pm at Cal State University, Hayward, California. Scholarships are available. Registration deadline: March 1, 2000. Seating is limited. $135 per person. Please call Dede Ranahan at (510) 885-2478 for more information.

Save the Date!

Our Seventh Annual Membership Conference will be held **August 11-13, 2000**, in Schaumburg, Illinois, just outside of Chicago, at the Hyatt Regency Woodfield.

Plans for the conference are being finalized now. Over 30 workshops will be presented by top-notch OCD researchers and clinicians. On Friday evening, experienced support group facilitators will offer different types of support groups.

Early registrants will have an opportunity to schedule an individual 20-minute consultation with an OCD expert.

Program and Registration information will be sent to all members in our conference brochure.

If you are not an OCF member, please call OCF at (203) 315-2190 and request a conference brochure, or membership information.

See you in Chicago in August!

Members' Forum

In Remembrance Of Leo Kay

To many of us he touched our heart and soul: his strength, his kindness, his inspiration, and his quick unchallenged wit. All of these traits composed only a small part of who he was and who he will be remembered as. Today I bring with this message both a sadness and fondness, in remembrance of Leo Kay. Leo died September 10th and it is with great sorrow that I bring this news to you. Perhaps some of you knew Leo, maybe you had heard of him, or even better maybe you were blessed with the great fortune of having been his friend, of knowing his spirit, his kindness, and his dedication to helping those in a similar plight.

Leo suffered from a number of enigmatic problems, ranging from panic disorder and depression, to problems resembling or relating to OCD. Leo suffered a lifetime of these symptoms, having only been spared from this pain in the last seven years of his life. Leo finally had discovered his own medication regimen, which when found had changed his life and his spirit forever. This spirit was contagious, and with renewed faith and energy, Leo reached out to many OCD sufferers. He told many his miraculous liquid Prozac story. He became a shining light and an inspiration to the OCD community, bringing HOPE, and STRENGTH to those whose lives so desperately needed it. I knew of Leo from a dear friend. He had changed her life indelibly, and became a facet of hope for me when I was struggling in the depths of my OCD and depression.

Leo, we honor your vitality, your spirit, and your wisdom. We are inspired by all that you had to offer and we will be forever THANKFUL for the love that you so generously poured out of your soul. Leo you will be DEEPLY missed. Your spirit will always be cherished and we will always celebrate our victories along side the very path you carved for us. Thank you Leo.

My regards to all of Leo's loved ones.

Karen Brenner

Members' Poetry Forum

Carved Smile

I see your face in front of me
Sensing your pain and agony
For I have not studied or learnt from any books
I can just tell from the way your face looks

Yeah you look content with that smile on your face
But to me I can't sense happiness
Not even a trace
You may deny what I know is true
Simply because you're a lawyer, doctor, or maybe a psychologist too

But what others can't hear I do see
For I have experienced the pain deep within me
Relieve yourself from this torturous cell
I know what it's like to live in a house of riches and still be in hell

The thoughts are continuous like a blizzard of snow
But who can you explain this to you simply do not know
For who would believe that a person of your stature
Could think these terrible things causing an internal disaster
Please understand I was a puppet like you
Pulled by agonizing strings
From surrounding thoughts that I did not bring

You're not asking for attention with these weird kind of acts
Simply you feel there is no corner to turn that is the fact
As the questions pour down like torrential rain
Hardest of all being how will I survive another day of this pain?
My secret rituals I continue to perform
Paralyze my body I can't move a bone

You have spoken no words But I know you experience this too
Because I was once wearing a carved smile just like you

Dedicated to: Dr. Fred Penzel, Dr. Robert Levine, Who have taken that carved smile off my face and replaced it with a real one.

Obsessive Compulsive Hoarding

by Randy Frost, Ph.D. and Gail Steketee, Ph.D.

Hoarding is a little studied and not very well understood behavior. It involves the acquisition of and failure to discard possessions that appear to be useless or of limited value. The behavior is quite common, and many people who hoard possessions do not suffer from a disorder. However, when this behavior becomes severe, it can cause significant distress and impairment. Hoarding behavior becomes clinically significant when it creates sufficient clutter so that parts of one's home cannot be used for their intended purpose. The problems caused by hoarding include safety and health threats, as well as interpersonal and even legal conflicts. Navigating a cluttered house can be dangerous, especially for older people or those with limited mobility. Excessive clutter is frequently associated with increased risk of fire and difficulty exiting the home due to blocked doorways and windows. Because adequate cleaning of cluttered homes is difficult, if not impossible, allergies and respiratory disorders can be exacerbated by hoarding behavior. In some cases, saving rotten food or contaminated food containers poses additional health-related concerns. In addition to these concerns, the extreme clutter often associated with hoarding frequently creates interpersonal conflict with those living in the home and may result in social isolation. Disorganization observed in the homes of people with this problem creates financial difficulties because finding and paying bills is frequently a problem. Such chaotic living conditions can create significant generalized distress as well.

Is hoarding a symptom of OCD?

Twenty to thirty percent of people diagnosed with OCD report hoarding as a major symptom. However, hoarding is associated with other disorders as well, such as anorexia nervosa, post-traumatic stress disorder (PTSD), dysphoria, dementia, and obsessive compulsive personality disorder (OCPD), for which it is one of the diagnostic criteria. In the mid 1970s, researchers suggested a syndrome of behaviors in the elderly that included hoarding, self-neglect and neglect of immediate surroundings. It was name Diogenes Syndrome after a 4th century BC Athenian Cynic who rejected all domestic comforts. Most often, however, hoarding is a symptom of obsessive compulsive disorder. Whether hoarding in the context of OCD differs from hoarding in the context of the other disorders just described is unknown. In fact, recently investigators have suggested that many patients thought to have Diogenes Syndrome actually have undiagnosed OCD. Sometimes hoarding appears in conjunction with other OCD symptoms, such as washing and checking fears and rituals, and sometimes it appears alone. It is not clear whether hoarding in the context of OCD is different from hoarding that is a part of OCPD. In the DSM-IV criteria for OCPD, hoarding is said to involve solely items without sentimental value, though this assumption appears to be erroneous.

Who typically has OCD hoarding?

People who are identified as having a problem with compulsive hoarding tend to be somewhat older than other OCD patients though most indicate that their hoarding behavior started when they were young. Consequently, the average age of onset for this problem is unknown. Nonpathological hoarding behavior may occur early in life and at some point, perhaps as possessions accumulate, the hoarding behavior becomes more difficult to control. It is not clear whether this problem affects women more than men. Most studies of compulsive hoarding include more women than men, but this may merely be because women volunteer for such studies more often than men.

Why do people with this problem save things?

The obsessional fear associated with hoarding is that something of importance might be lost by discarding. The feared loss may be in the form of monetary value, lost opportunity, or even the loss of part of oneself. Discarding or giving away possessions can provoke grief-like reactions in people who hoard. Fears about loss are related to beliefs commonly seen in other forms of OCD. For instance, people who hoard often feel an exaggerated sense of responsibility for being prepared and for not wasting resources. These beliefs can be so powerful that the relative importance of objects is exaggerated. People who hoard tend to want to maintain control over their possessions, often so that no harm will come to them or so that they are given only to people who will take proper care of them. People who hoard also overestimate the threat posed by discarding a possession, typically fearing criticism from others or being unprepared. Finally, efforts to discard are accompanied by lack of tolerance for the uncertainty that a use may be found tomorrow for a possession that was discarded yesterday.

Hoarding is associated with several other characteristics that are part of the clinical

picture. Most people who hoard are often highly perfectionistic, and excessively concerned with making mistakes.

These mistakes typically concern the idea that something important will be discarded, with serious repercussions. People who hoard also have problems with making decisions, not merely decisions about possessions, but about even minor events such as what to wear and what to order in a restaurant. These problems may result from difficulties attending to, organizing, and weighing information relevant to a decision.

Hoarding behavior appears to run in families. This suggests that it may be influenced by modeling or possibly that it is genetically transmitted. While some have suggested that hoarding is associated with deprivation early in life, there are as yet no scientific data to support this hypothesis.

Who else gets involved in cases of hoarding?

In cases where the health and safety of the individual or their family are concerned, local departments of health or social service agencies frequently become involved. In some cases, the result is eviction or seizure of possessions and their disposal by local authorities. In such cases, the immediate health and safety risks may be reduced, but the clutter is frequently recreated within a short time. Housing is an area of particular concern for people who hoard. For those who rent, worry that the landlord will start eviction proceedings is a constant threat. For people who own a home, allowing repair men into the house is often a problem. Elder service agencies frequently are involved in trying to help elderly hoarders who want to continue living on their own.

How is compulsive acquisition related?

Hoarding is nearly always accompanied by excessive acquisition of possessions. This may include both compulsive buying as well as the compulsive acquisition of free things. For example, a person who hoards may visit the post office daily to acquire unclaimed newspapers or magazines. Frequently, people who hoard are unable to refrain from buying bargains, even though they have no use for them. Other forms of compulsive acquisition include picking up extra handouts, brochures or other free things, and even picking through dumpsters or other people's trash. Compulsive acquisition is also linked to fears of losing something or making mistakes, in this case about something not yet in their possession.

What other problems are associated with hoarding?

In addition to excessive acquisition and problems discarding, hoarding is characterized by problems with organization. People who hoard are rarely able to organize their possessions to prevent clutter, and the process of organizing and putting items away seems difficult and fraught with anxiety. Hoarding may be accompanied by attention deficit disorder, so that organizing and discarding are especially troublesome tasks because the individual is easily distracted from routine tasks. In addition, those who hoard also commonly experience significant depression, especially when their lives are substantially disrupted by this behavior. Social phobia and isolation also occur more frequently than would be expected by change.

What types of treatment are appropriate?

Hoarding may be more difficult to treat than other forms of OCD for several reasons. People with this problem have a hard time recognizing the problem or its seriousness, and state that they prefer to live in a cluttered space rather than give up their potentially valuable possessions. Consequently, motivation to change is sometimes limited. Also, by the time the problem has become serious enough to warrant help, the volume of possessions would pose a problem even for people who do not have problems deciding what to discard. For those who recognize the problem and want to do something about it, cognitive behavior therapy designed specifically for hoarding has show some initial promise as an effective treatment. This approach involves working on the behaviors associated with hoarding (e.g., organization, acquisition, and discarding of possessions), as well as the cognitive aspects of the disorder such as emotional attachments to possessions, worries about putting objects out of sight, and erroneous beliefs about the nature and function of possessions as well as decision-making skills. It should be noted that while this approach has shown initial promise in several case studies and case series, more research is needed to establish its efficacy.

People seeking help with this problem may also wish to try medication, however, there is as yet little evidence that the serotonergic medications that have proved so helpful for OCD are effective in the treatment of hoarding.

Randy Frost, Ph.D., is Professor of Psychology at Smith College. He can be reached at (413) 585-3804. Gail Steketee, Ph.D., is Professor, Associate Dean of Academic Affairs at Boston University, School of Social Work. She can be reached at (617) 353-3785.

Affiliate News

Summer Camp for Children with OCD

The Greater Boston Affiliate of the Obsessive-Compulsive Foundation (OCF), in conjunction with the OCD Institute, is sponsoring a co-ed, residential summer camp for children with OCD. To be held this August 19th-31st at Camp Wing in Duxbury, MA, the camp will be an environment where children diagnosed with OCD can meet and socialize with peers. The camp offers a wide variety of activities including swimming, boating, softball, soccer, volleyball, basketball, nature walks, arts and crafts, and a ropes course. Staff trained to work with children with OCD will provide education about OCD, treatment, and lead support groups. Staff, who will live with and supervise the campers at all times, will be oriented and trained to assist campers in managing their symptoms so that they can take full advantage of all the activities the camp has to offer.

The camp will be available to 50 children between the ages of 8 and 12 who have successfully completed the 1999/2000 academic year. Given the relatively brief time frame of the camp, the focus will be primarily on recreation, socialization, and support, rather than on treatment.

The admission criteria and application process can be found in the camp's brochure. Camp tuition will be $1875, and does not include transportation. If you would be interested in receiving more information about the camp, **please call Judie Beshwaty at 617-855-3371 and we will be pleased to send you our brochure.**

The Obsessive-Compulsive Foundation of Greater Boston 1999-2000 Lecture Series and Support Groups

Co-Sponsored by McLean Hospital.
First Tuesday of each month at 6:30 pm, McLean Hospital, de Marneffe Building, Rm. 132

March 7: How Mass. rehab can get you back to work
Karen Mael

April 4: Family expressed emotion and treatment outcome for people with OCD
Leslie Shapiro, LICSW
Mass. General Hospital OCD Institute

Support groups will follow at 7:45 pm for people with OCD, family members and friends. A support group for children and adolescents will be led by Lisa Bertman, Ph.D., a therapist from the OCD Institute. For more info call her at (617) 855-2926. For additional information, call the OCF of Greater Boston at (617) 376-3784.

The following is the conclusion to an article that ran in the November/December OCD newsletter

The RIGHT Stuff

Obsessive Compulsive Personality Disorder: A Defect of Philosophy, not Anxiety

by Steven Phillipson, Ph.D.

Owning Truth

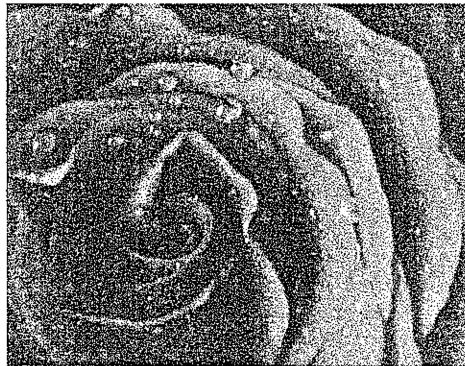
We all periodically have such confidence in what we are saying that statements such as "I'm sure of it" or "The fact of the matter is..." play a natural part of our everyday vocabulary. For persons with OCPD, facts and confidence are all too often turned into "I'm RIGHT and you're WRONG". "The way I see it represents the way it is, end of story". For others, refusing to yield to the "correct perspective" often entails encountering tension and discord. This manifestation of OCPD entails ones adamantly guarding their dogmatic beliefs to such a degree that casual conversation often converts minor disagreements into heated debates. The relative importance of any topic (i.e. comparing the effects of regular gas vs. high test on a particular car's performance) rarely is of consequence in determining the degree of the intensity expressed in the midst of the debate.

It would not be unusual for an OCPD sufferer to literally take delight in being wronged, since it affords them, what they perceive, as the justified opportunity to deliver a steep punishment. The term "righteous indignation" was probably conceived with this perspective in mind. Crossing a person with OCPD provides them the license to hold a grudge and forever hold your mistake over your head.

In a conflict with someone who has OCPD, the non-OCPD person might be motivated to desperately seek closure. In the process of attempting conflict resolution, the non-OCPD might discover that every minute the quagmire becomes deeper and deeper. It is almost as if the mere effort to find resolution is a punishable offense. In a close relationship, encountering this zone of contempt is bewildering and frightening. All one wants to do is to bring this controversy to an end, and then, you are punished for not being willing to deal with the issue at hand. Within this zone, the person with OCPD feels a great need to bring about absolute clarity for the issue to be resolved. Once again this need for the perfect resolution creates a seemingly never ending tweaking of the issues. Agreeing to disagree is rarely a reasonable solution and often not in the scope of the OCPD's world.

Interpersonal Relationships

For many who have close contact with an OCPD sufferer there can be a pervasive experience of being ill at ease, while in the company of someone with OCPD. Often, being with persons who evidence this diagnosis, feels like walking in a field of land mines. One never knows when you're going to step on one and pay a heavy emotional price for crossing the rigid standards. This ever present threat creates a tremendous amount of trepidation, resentment and tension. These land mines can present themselves in association with seemingly random topics.



Within marital or familial relationships the divisiveness of this condition is most felt. Since ideology and correctness is placed before love and loyalty, divisiveness can break familial ties. Spouses can be subjected to daily scrutiny and given repeated feedback in a non-loving or non-supportive manner. The standard bearer must run his or her house like a tight ship. From the children being kept in line (seen but not heard) to the outside appearance of the house, well manicured and tidy. The expression, both physically and emotionally, of tender feelings for "loved ones" is often painfully absent. Corporal punishment is not unusual since the mentality of "spare the rod and spoil the child" is even endorsed in the Bible. Wreaking humiliation seems to be just punishment since it closely approximates the inner experience of the OCPD sufferers reaction to being wronged.

In interpersonal relationships we all tend to hope for a little leeway in being given feedback for mistakes that we make. Persons with OCPD tend not to find it within themselves to provide a nurturing environment where being human and fallible is accepted. Instead they feel put upon by others mistakes and take license in extracting a heavy toll for even an initial infraction. "Persons should know better and mistakes are just not to be tolerated." For those familiar with the OCPD's style, bailing out of a conversation and avoiding future areas of debate, is a pervasive response pattern. Not surprisingly this style of interaction has devastating effects on the great majority of relationships persons with OCPD have. Fault-finding is the tendency for OCPD's to chronically pick out the flaws in others, especially those close enough to them to mention it. "You always misuse the word affect instead of saying effect!" "Your hair is always so messy, don't you have any self respect?" It seems as if through criticism the receiver of the feedback will be inspired to get their act together.

For the OCPD sufferer, it is not uncommon for them to seek out the company of a significant other where their partner's personal disposition is that of being passive and non-confrontational. For a long-term significant relationship to survive with this diagnosis, it is almost essential for the partner to have great depths of resilience and dependency. Many OCPD relationships involve a clear distinction between the domineering and controlling spouse and the passive-dependent spouse.

Isolation due to rigidly held high standards is also a common result of OCPD. When perfectionistic standards are applied toward a partner's minute bodily defects or quirky personal style, the devastation wreaked within intimacy is astounding. I have all too often worked with clients who have legitimized ending relationships due

to such minutia as a significant others bad breath, small shoe size or eyebrows thickness. An article written in New York magazine, a few years ago, portrayed a satirical conversation which went something like this: "She's a Ph.D., expert skier, loves children and animals, and encourages me to spend as much time out with the guys as possible ... it's just a shame she speaks French with a southern dialect". When this aspect of OCPD is manifested there is typically a pattern of failed relationships. The sufferer tends to consistently withdraw from a relationship soon after the development of intimacy. The awareness of the defect in one's partner as time goes on becomes so magnified, that after a while, the slight flaw which was not even noticed initially, becomes the only feature which is seen.

Poor social skills are often a consequence of a life-long pattern of rigid thinking. Being motivated to attend to subtle cues within ones social environment is lost due to the overriding perspective that "my way is the right way". Taking liberty to disclose radical opinions of facts, which are of an extreme nature, in the presence of a novel relationship or non-intimate acquaintances is a common characteristic. Whereas in a novel social setting decorum pressures persons to withhold extreme positions, the OCPD sufferer feels that a lack of genuineness is wrong and being totally open, no matter what the consequence, is the only option. "If others are offended by what I say, too bad for them".

In professional relationships, subordinates of many OCPD's are often intimidated and frequently berated. Staff may experience tremendous inhibition in speaking freely about topics where there is not absolute certainty regarding the correctness of the statements. This environment facilitates the stifling of creativity and risk taking. Often the chain of command from above reinforces or ignores this style, since it appears that the manager is just being vigilant and instilling the company's commitment to excellence.

Friendships (however long-lasting they may be) are often tenuous at best. Persons with OCPD, at the more extreme end of the continuum, project an air of consternation and rigidity. The eventual breakdown of casual relationships comes as a consequence of chronic tension and failed expectations. The internal schema (style of viewing life circumstances) of the sufferer is incapable of learning from these repeated failures due to the dogged conviction that the other person was at fault, and therefore the termination of the relation was justified.

Strict Moral Standards

"Premarital sex is wrong and it means that persons are tainted if they have ever engaged in it."

"Girls who wear make up are loose and promiscuous."

"Men who allow their wives to work are inadequate providers."

Moral righteousness and preaching morality as a dogmatic necessity is not an uncommon expression of OCPD. The avoidance of discussing religion or politics is certainly wise in the presence of the OCPD sufferer. Both of these realms are steeped in the potential for the OCFP sufferer's truth to override consideration and respect.

Excessive religious observance, as in strict adherence to ritualistic aspect of daily or weekly routines, is a potential component of OCPD. If a child asks for a rationale for following through with certain age old traditions the OCPD parent may respond with "You just do it and never question the relevance". Often persons with this form of OCPD believe in literal interpretations of the Bible or Koran. Adamantly endorsing the idea that the world was created some 5864 years ago, despite the existence of rocks carbon dated to over a million years ago, would not be unexpected. Using the Wrath of God as a means of modifying behavior is often an unfortunate component of OCPD. Of course, religious intolerance is not surprisingly a derivative of this style of thinking. Finding fault with different views or creating fractions within divergent religious sects is not uncommon.

Treatment Implications

The treatment of OCPD can be complex and lengthy. Generally speaking, the focus of Cognitive-Behavioral treatment for OCPD entails helping these individuals develop a greater tolerance to the notion that the world is made up of gray, not the clearly defined black and white lines of rigidly held beliefs. As is the case with all treatments there is an utmost emphasis on developing rapport and trust within the therapeutic relationship. Educating the client about the diverse nature of this condition offers the sufferer the option to identify those aspects of OCPD which are most salient to their lives. Having the client identify that these dispositions serve as barriers at all is a monumental achievement.

The treatment may focus on breaking down and intervening on specific individual aspects within the spectrum of OCPD. A standard cognitive-behavioral intervention might deal with the hoarding (using exposure and response prevention methods), while social skills training and role-playing might strengthen the ability to make requests or provide feedback in an effective and unprovoking manner. Overriding all of the specific interventions would be a sensitivity to helping the sufferer relinquish their dogmatic belief system. Letting go of "truth owning" and relating to one's world without needing to be "right" is a tremendous ambition. The dividend it pays is incomprehensible.

As has been previously stated, the existence of OCPD has devastating effects on relationships. The therapeutic relationship is unfortunately not excluded. Therapists may well be advised to forewarn all persons with OCPD that at some point in the course of therapy the clinician will inadvertently behave in a manner which will violate the client's perfectionistic standards. Rather than responding by terminating the relationship, this juncture provides the client with an opportunity to learn how to manage the conflict. Playing out conflict resolution in the course of therapy can be a powerful therapeutic tool. Being real and available to the client is critical. Once rapport has been established, giving honest and immediate feedback about the dynamics within the therapeutic relationship is imperative. Keeping the channels of communication open so that at the point where the client most desires ending the relationship, becomes the point where effective communication can take place to strengthen the foundation of the partnership. In all honesty, approximately 50% of OCPD clients remain on board for the long haul. Rather than seeing the actual conflict within the therapeutic relationship as the unavoidable manifestation of why they came into therapy in the first place, many bail prematurely due to the overwhelming sense of outrage that the doctor has made a mistake.

This article represents a radical departure from the style of most of my previous writings. I am aware that there is an emphasis on the aftermath within oneself and on others, rather than a primary focus on understanding and compassion. I strongly believe that through being informed about this condition's manifestations, people can better seek appropriate treatment. Living out the patterns of OCPD for oneself and for others around you is devastating. If you are at the end of your rope and these characteristics are relevant, I strongly suggest you seek new paths.

Steven Phillipson, Ph.D., is the Clinical Director of the Center for Cognitive-Behavioral Psychotherapy in New York. He can be reached at (212) 686-6886.

Would you like to submit an article for the next *OCD Newsletter?* Deadline: March 15

Research Digest

Article reprints may be obtained from the OC Foundation for $3.00 per copy for shipping and handling. These articles and additional information on the latest research on OCD and related disorders, may also be obtained from the Obsessive Compulsive Information Center, Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison, WI 53717, (608)827-2470

Selected and abstracted by Bette Hartley, M.L.S. and John H. Greist, M.D.

Madison Institute of Medicine

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

Alteration of the platelet serotonin transporter in romantic love

Psychological Medicine, 29:741-745, 1999, D. Marazziti, H.S. Akiskal, A. Rossi et al.

In subjects who had recently fallen in love and were still at the early, romantic phase of the relationship, the density of the platelet serotonin transporter was similar to that found in patients with OCD, levels which were significantly decreased from the normal control levels. This study suggests common neurochemical changes involving the serotonin system are shared by individuals newly in love and patients with OCD. This shared physiologic effect may result from a similarity between an overvalued idea, that early obsessive preoccupation about the new partner and an OCD obsession.

Clomipramine vs. desipramine crossover trial in body dysmorphic disorder: selective efficacy of a serotonin reuptake inhibitor in imagined ugliness

Archives of General Psychiatry, 56: 1033-1039, 1999, E. Hollander, A. Allen, J. Kwon et al.

Body dysmorphic disorder (preoccupation with an imagined or slight defect in appearance) is a common and disabling disorder associated with high rates of delusional symptoms and suicide attempts. Although preliminary studies suggest that serotonin reuptake inhibitors (SRIs) may be effective for body dysmorphic disorder, this is the first controlled treatment trial. Results show that clomipramine (Anafranil), an SRI, is more effective than the control medication, desipramine, a norepinephrine reuptake inhibitor, in the treatment of body dysmorphic disorder and is effective even with delusional patients.

Cognitive-behavioral therapy as an adjunct to serotonin reuptake inhibitors in obsessive-compulsive disorder: an open trial

Journal of Clinical Psychiatry, 60: 584-590, 1999, H.B. Simpson, K.S. Gorfinkle and M.R. Liebowitz

Many studies have reported that behavior therapy can help significantly OCD patients. The advantage of the present study is that it was designed to separate the medication and behavior therapy effects. Results from this trial show that cognitive-behavior therapy using exposure and ritual prevention can lead to a significant reduction in OCD symptoms in patients who remain symptomatic despite an adequate trial of an OCD medication.

A previous study suggested that inositol, one of the B vitamins, may be effective in the treatment of OCD. The following two studies evaluated inositol as an augmenting agent of serotonin reuptake inhibitors (SRIs). The addition of inositol to the ongoing SRI treatment was not beneficial in either study.

Inositol augmentation of serotonin reuptake inhibitors in treatment-refractory obsessive-compulsive disorder: an open trial

International Clinical Psychopharmacology, 14: 353-356, 1999, S. Seedat and D.J. Stein

Ten OCD patients who had failed to respond to current and previous trials of SRIs participated in a trial of inositol (18 mg/day) augmentation for 6 weeks. Inositol augmentation of a SRI did not lead to significant improvement in the majority of these patients.

Inositol versus placebo augmentation of serotonin reuptake inhibitors in the treatment of obsessive-compulsive disorder: a double blind cross-over study

International Journal of Neuropsychopharmacology, 2: 193-195, 1999. M. Fux, J Benjamin and R. H. Belmaker

This double-blind study compared the addition of inositol versus placebo to ongoing SRI treatment in ten OCD patients. No significant difference was found between inositol and placebo treatment augmentations.

Family accommodation of obsessive-compulsive symptoms: instrument development and assessment of family behavior

Journal of Nervous and Mental Disease, 187:636-642, 1999, L. Calvocoressi, C.M. Mazure, S. V. Kasl et al.

Relatives frequently accommodate patients' obsessive-compulsive symptoms, and clinicians hypothesize that such accommodations adversely affect treatment outcome. Researchers found family accommodation was significantly associated with patient symptom severity and dysfunction, and with relatives' own obsessive-compulsive symptoms. Also of interest is that nearly 70% of relatives in this study experienced some degree of distress when accommodating patients. This new scale will provide clinicians with a useful tool for assessing family accommodation and for identifying families who may benefit from interventions aimed at developing family coping strategies.

Randomized trial of plasma exchange vs immune globulin in childhood-onset obsessive compulsive disorder (OCD)

Transfusion, 39 (10): S 112-1999, S.F. Leitman, R.A. Werden, M.A. Garvey et al.

In children, worsening of OCD symptoms may occur after infection with streptococcal bacteria. If post-streptococcal autoimmunity is the cause of the worsening symptoms, then children might respond to treatments such as plasma exchange or intravenous immunoglobulin (IVIG). Results from this sham procedure controlled study found that plasma exchange and IVIG were both effective in lessening of symptom severity for children with strep-triggered OCD and tic disorders. More than 80% of the patients who received IVIG or plasma exchange remained "much" or "very much" improved one year after the treatments.

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Loves Me? Loves Me Not?

(Continued from page 1)

Finally, there was Henry, a 22-year old graduate student. Things had gone a bit further in his case, and not in a particularly good way. Henry's girlfriend, a fellow student, had broken up with him two months before he came to me, after an eight-month relationship. At the time, she explained that she just didn't think he was her type, even though she thought he was "a nice guy."

Unfortunately, this was not enough for Henry. As in the case with Maria, he believed that there was more to the story than his girlfriend had told him. He wondered if perhaps she had broken up with him over a simple misunderstanding, which if corrected, would fix everything. He began calling her on the phone several times per day to ask the same questions, and when she began to screen her phone calls, he started to show up at her classes and hound her with the same questions. He also asked her friends some of these questions. Unfortunately for him, she complained to campus security about this, and he soon found himself in the dean's office to explain his behavior. Only the threat of expulsion from his school forced him to stop, and he resolved to quit before it was too late.

His good intentions didn't last more than about two weeks. He then began to wait for her outside her house. This resulted in her obtaining a legal order of protection from a judge, and a threat of arrest if he called her on the phone, or came within one hundred yards of her or her home. The word "stalker" was mentioned. "This just isn't me," he told me emphatically. "I really want to stop, but these doubts just eat away at me. It's like they just won't leave me alone. I have to have answers."

These people were not simply wrestling with relationship problems. What they were dealing with was a neurobiological disorder. All three were subsequently diagnosed with OCD, known in former times as "the doubting disease." This is not simply ordinary doubt. It is doubt raised to the level of a serious disturbance. An obsessive thought can be very insidious and persistent. It is like a severe and maddening itch that cannot be scratched.

Why OCD picks on particular topics remains a mystery. It may be something previously important to the sufferer, or not. At times, it does seem to have an uncanny way of interfering with whatever the sufferer cares about the most.

When OCD intrudes into relationships, the effects can be severe. Often, the sufferer doesn't realize that OCD is really the underlying problem – he or she is just too close to what is happening. The partner on the receiving end is equally mystified, and cannot comprehend what has happened to the original person, the one at the beginning of the relationship. Problems such as these can build up gradually over years, or may begin suddenly. Sometimes, in looking back over past relationships, a sufferer can begin to see a pattern of smaller occurrences, though perhaps not as severe.

Obsessions are intrusive, repetitive, doubtful thoughts that suggest that harm may come to the sufferer or others in some way. Compulsions are any mental or physical activity performed for the purpose of relieving the anxiety caused by obsessions. In E&RP, sufferers are gradually exposed to those things that bring on their fearful obsessive thoughts, so that they may gradually build up a tolerance to them, and not feel the need to question, check, or perform other compulsions in order to relieve the anxiety. Those who practice this diligently find themselves getting better over time, rather than worsening, as they might first have predicted.

Although all three believed that the answer to their doubts had to be out there somewhere, it was explained that this was really an internally generated problem that had to be confronted rather than avoided. Their attempts to escape their obsessions by getting more information had only led to more doubt and thus, further difficulties. They were all forced to accept that they had gone as far with their compulsive checking and questioning activities as they could safely go; and it was clear that they would never resolve their doubts in these ways. Their solutions had ironically become their problems.

Each of these three individuals had eventually found his or her way to treatment. Ed insisted at the first visit that he did not want his wife to find out that he was going to therapy. Maria actually brought her boyfriend to her second session so that he could learn about what she was dealing with, and that her urge to question him wasn't her fault. Henry, like Ed, came alone, but hoped to find out enough about the disorder to be able to eventually write his ex-girlfriend a letter and send some OCD pamphlets so she would understand that he was not a "crazy" or hostile person.

Treatment options for all three consisted of a type of behavioral therapy known as Exposure and Response Prevention (ER&P), together with medication in the form of SSRI-type antidepressants. Ed opted for behavior therapy alone, while Henry and Maria decided to combine treatments.

Now, their problems had to become their solutions. That is, the things they had been avoiding would now be used to help them. Please note that the following descriptions of their therapies are only simplified summaries. There is actually a lot more to behavior therapy than can be described in this article.

Ed listened to tapes and did writing assignments about how he would remain "trapped" and miserable in a loveless marriage. He also watched video's and read books on similar themes. He was assigned to look at pictures of attractive women, and , discreetly watch attractive women he saw in public places, while telling himself how much happier he would be with them than with his wife.

Maria also listened to tapes and did writing assignments. Her exposure centered on the theme that there were a great many things she would never know about her boyfriend's past, that she would never really understand him, and he would never tell her about any of these things. She was assigned to look at pictures of her boyfriend's former girlfriend posted on her walls with question marks drawn all around them. She was also forbidden to question her boyfriend about any of her pet subjects. Fortunately, her boyfriend was willing to cooperate with her therapy. Whenever she slipped and asked him a question (no one gets well perfectly), he was directed to say to her: "Sorry, you know I'm not allowed to tell you." If she told him: "You're not helping me." He was also directed to say: "I am helping you. I'm helping you to recover."

Henry, of course, was assigned to stay as far away from his former girlfriend as possible, and was forbidden to call her or her friends. His audiotapes and writing assignments exposed him to his obsessive thought that he would never *really* know why his ex broke up with him; he would live out the rest of his life without that information; would never get back together with her; and it would no doubt harm his future relationships.

He read books and watched movies about break-ups. He was directed to post signs around his apartment that said such things as: "You'll never really know," or "She's hiding the truth from you."

In these particular cases, things turned out well. All three experienced anxiety at first, but over time they eventually lost interest in their particular subjects. They discovered after repeated exposure that they could not feel bored and anxious at the same time. At the infrequent times when their obsessive thoughts did occur, they now provoked little or no reaction. Maria and Henry both felt the medication had given them an *edge*, as it had reduced the frequency and intensity of their thoughts. All eventually came to see that their fears could not simply be avoided or neutralized, and that there was no true escape other than facing them.

Although these three individuals were fortunate enough to get help, there are, no doubt, many others out there with similar stories who do not even understand what they are up against, or that others suffer in similar ways. They may believe that they only have some kind of relationship problem, and are not aware that help is available. Some have lost important relationships, and may even have had tangles with a justice system that simply didn't understand them. If your story is similar, don't wait until there are serious consequences. Get help as soon as possible.

Fred Penzel, Ph.D., is a licensed psychologist specializing in the treatment of OC disorders for over 17 years. Dr. Penzel is a member of the OCF Scientific Advisory Board, and is a frequent contributor to the newsletter. He can be reached by e-mail at: penzel@attglobal.net.

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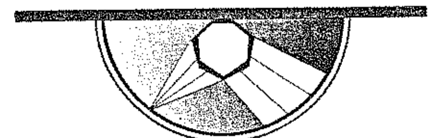

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